Nutrition Action for Systemic Change (NASC) Technical Assistance Facility (contracted through Framework Agreement EACDS 2 Lot 4)

Training of Trainers Guide: Integrating nutrition through health service contact points in FCDO programmes, Somalia

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About This Publication

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Contents

Abbreviations

ANC	Antenatal Care
BL	Better Lives
CC	Counselling Card
CF	Complementary Feeding
EBF	Exclusive Breastfeeding
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunisation
FCDO	Foreign, Commonwealth and Development Office
FMOH	Federal Ministry of Health
GMP	Growth Monitoring and Promotion
IFA	Iron and Folic Acid
IYCF	Infant and Young Child Feeding
LBW	Low Birth Weight
MIYCAN	Maternal, Infant, Young Child and Adolescent Nutrition
MMS	Multiple Micronutrient Supplementation
MUAC	Mid-Upper Arm Circumference
OTP	Outpatient Therapeutic Programme
PLW	Pregnant and Lactating Women
PBWG	Pregnant and Breastfeeding Women and Girls
PNC	Postnatal Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SAM	Severe Acute Malnutrition
SGA	Small for Gestational Age
ToT	Training of Trainers
TSPF	Targeted Supplementary Feeding Programme
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
WASH	Water, Sanitation and Hygiene
WAZ	Weight-for-age z-score
WLZ	Weight-for-length z-score

Glossary

Infant	A child less than 12 months of age.
Health Workers	Health professionals, health associate professionals, personal care workers in health services, health management and support personnel, and other health service providers. Health workers make up the health workforce and are engaged to deliver health care to individuals and populations as part of the health system.
Maternal Nutrition Interventions	The package of maternal nutrition interventions is based on WHO guidelines and includes: counselling on dietary diversity and quantity, IFA supplementation, MMS and counselling, weight gain monitoring and counselling, and breastfeeding counselling and support.
EPHS	Essential Package of Health Services, Somalia 2020. A revision of the EPHS 2009, the package is the vehicle for delivering a set of cost-effective, equitable, accessible and affordable health services that address the immediate needs of the Somali people.

The Training of Trainers (ToT) Package

Introduction

This training package was originally requested by Better Lives programme staff from FCDO and UNICEF to strengthen the integration of nutrition services to deliver the Essential Package of Health Services (EPHS) and strengthen the RMNCAH component. FCDO and UNICEF identified a lack of quality training of health facility staff on nutrition knowledge across health services, including prevention of malnutrition. They highlighted specifically the lack of inclusion of nutrition counselling in ANC/PNC services, particularly maternal nutrition, as well as early identification (and treatment) of wasting.

To address these identified gaps, this ToT package has been designed as a resource for training health workers in health facilities in Somalia, equipping them with the knowledge required to deliver quality nutrition services to women, adolescent girls, infants and young children at key health service contact points. The ToT package has NOT been designed to replace technical training of health workers, but rather to build their capacity to include nutrition services in their daily work in delivering the EPHS, through the integration of nutrition interventions at key contact points with pregnant and breastfeeding women and girls (PBWG) and infants.

Signposting to technical tools and additional training materials is included in each module under resources.

The intended use of this ToT package is:

- As training material to be used by FCDO programme staff, C+ Consortium programme staff, CSO and INGO partners, and MoH district health officers to train health workers in health facilities
- As reference material to be used by health facility health workers and their supervisors to improve nutrition integration into health services.
- The ToT can also be used as a generic training material, and adapted to the specific country context[1].

This ToT package was developed using methodologies and content appropriate for use with health workers at the facility level. The content of the package includes materials specifically developed for this training, alongside content adapted from a range of resources, including those created by UNICEF, USAID, Save the Children, the Ministry of Health and Human Services, and the Federal Ministry of Health (FMOH) Somalia. The package is intended to be used in conjunction with the UNICEF IYCF Counselling Package and Counselling Cards, Somalia 2026.

The package was piloted in Mogadishu in December 2025 and revised accordingly in January 2026.

Alignment with International and National Guidelines

This training package has been developed to ensure consistency with the latest international evidence-based guidance and national standards. In particular, it is aligned with the 2023 World Health Organization (WHO*) Guideline on the prevention and management of wasting and nutritional oedema in children under five years of age*. Additionally, the package incorporates the Somalia Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN) guidelines to ensure contextual relevance and appropriateness for health workers operating in Somalia.

During the development of this package, the Somalia national guideline on the prevention and management of wasting and nutritional oedema—also referred to as the Integrated Management of Acute Malnutrition (IMAM) guidelines—was available only in draft form and was undergoing piloting. Consequently, all training materials have been designed to align with the draft version of these guidelines. It is important to note that, as the national guidelines are finalised, the training materials included in this package should be reviewed and revised accordingly to reflect any updates or changes in national policy and practice. This approach ensures that the materials remain accurate, relevant, and in line with the best available guidance.[2]

[1] Contact points should be adapted to the country context, and content aligned with national nutrition guidelines. Additionally, country-specific UNICEF IYCF counselling package and counselling cards should be used where available.

[2] IMAM Guidelines are currently planned for release in June 2026.

Package content

The package consists of the following six modules and accompanying slide deck:

Module 1 *Integrating nutrition at key contact points in the health facility*

Module 2 *An Introduction to Nutrition*

Module 3 *Maternal and Adolescent Nutrition*

Module 4 *IYCF – Breastfeeding*

Module 5 *IYCF – Timely introduction of appropriate complementary feeding*

Module 6 *Growth Monitoring and Promotion*

In addition, the zip file contains supporting documents including participant and facilitator agendas, key training materials and facilitator profile.

Training of Trainers Objective

The intended use of this ToT package is to equip heath workers with the knowledge needed to effectively integrate nutrition in health services including the delivery of Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN) interventions at **key health service contact points:**

- Antenatal visits at 8-12 weeks, 24-26 weeks, 32 weeks and 36-38 weeks[3]
- Skilled Delivery at Birth, PNC visits at weeks 1 and 6
- Childhood immunisations at 6 weeks, 10 weeks and 14 weeks (Penta vaccine)
- Childhood immunisation at 12 months (Measles vaccine)

By the end of the training, participants will be able to integrate appropriate MIYCAN interventions at key health facility contact points with mothers and infants

ToT Agenda

The three-day ToT programme is designed to strengthen participants' understanding of how and why nutrition should be systematically integrated into health service delivery, while also building their capacity to effectively facilitate and cascade the training to others. The training begins with an orientation and refresher on adult learning principles and facilitation skills, followed by a structured introduction to nutrition integration at key health service contact points, emphasising the rationale for integration and its contribution to improved maternal, infant, and child health outcomes. Participants then progress through modules covering maternal and adolescent nutrition, infant and young child feeding (IYCF), and growth monitoring and promotion, with a focus on practical application within routine health services. During the training, facilitator demonstrations are combined with interactive group work and multiple teach-back sessions, allowing participants to practise delivery, receive peer feedback, and reflect on effective training techniques. Detailed schedules for both participants and facilitators, outlining sessions, timings, and formats are provided in the accompanying training materials file.

[3] Eight ANC contacts are recommended by WHO and in the Somalia Reproductive Maternal Neonatal Child and Adolescent Health Strategy 2016-2023

Proposed 3-day Training Schedule

This 3-day schedule is provided as an indicative example of how the training modules may be delivered to health workers at facility level. It is intended to support facilitators in planning cascade trainings and may be adapted based on available time, participant workload, and service delivery constraints. Where the schedule is adapted, facilitators are responsible for ensuring that core technical content is retained.

Day 1	Day 2	Day 3
WELCOME		
Session 1: Introduction to the Training: icebreaker, objectives, expectations, pre-training assessment (60 mins) **Session 2: Module 1 - Integrating nutrition at key contact points in the health facility** (75 mins)	**Session 7: Module 4 – Infant and Young Child Feeding:** Exclusive breastfeeding, risks of artificial feeding, early initiation of breastfeeding (60 mins) **Session 8: Module 4 – Infant and Young Child Feeding:** Recommended breastfeeding practices, responsive care and feeding practices (50 mins)	**Plenary review of key messages across all modules**
MORNING BREAK		
Session 3: Module 2 – An Introduction to Nutrition Part 1: Group work and discussion (60 mins)	**Session 9: Module 5 – Infant and Young Child Feeding:** Timely introduction of appropriate complementary feeding (90 mins)	**Practical sessions and case discussions:** - Counselling scenarios - Challenges at the facility level - Linking to HS contact points
LUNCH		
Session 4: Module 2 – An Introduction to Nutrition Part 2: Theory (45 mins) **Session 5: Module 3 – Maternal and Adolescent Nutrition** Maternal nutrition interventions (60 mins)	**Session 10: Module 5 – Infant and Young Child Feeding:** Integration of IYCF counselling into health service contact points (30 mins) **Session 11: Module 6 - Growth Monitoring and Promotion** Early Identification of infants at risk of poor growth and development (45 mins)	**Identification of additional training needs:** - Counselling skills - MICYAN **Final Session:** feedback forms and presentation of certificates of completion **Final wrap-up**
AFTERNOON BREAK		
Session 6: Module 3 – Maternal and Adolescent Nutrition Identifying maternal nutrition interventions for each contact point (60 mins)	**Facilitated discussion, Q&A, practical exercises.** **Post-training assessment**	
Recap and wrap-up Day 1	**Recap and wrap-up Day 2**	

Assessment of Learning

A pre-test provides an overview of participants' baseline knowledge, helping to identify areas where additional support may be required during the training. The post-training test measures the knowledge gained, providing insight into participants' progress and the effectiveness of the training. Additionally, a Q&A session at the end of each topic enables the trainer to gauge participant understanding in real time, reinforcing key concepts and addressing any questions.

A post-training assessment form is also included in order to measure knowledge gained through the training, highlight specific areas where participants have improved and areas where further clarification may be needed.

The Importance of Nutrition Integration Actions

WHO guidelines outline **Essential Nutrition Actions** that address malnutrition in all its forms throughout the life-course[4]. The integration of nutrition actions such as Infant and Young Child Feeding (IYCF), nutritional screening of mothers and infants, and nutrition interventions (such as the provision of supplements) and counselling into health services is essential for the prevention of wasting and stunting, to break the cycle of malnutrition, and for the improvement of health outcomes across the life-cycle.

Table 1 outlines the nutrition actions that can be integrated at health service contact points in health facilities, as well as the potential benefits and risks associated with each.

Integrated Action	Contact Points	Potential Benefits	Risks and Other Considerations
Include **IYCF** in facility-level programmes – counselling mothers and caregivers on recommended infant and young child feeding practices from 0-24 months.	ANC visit 4 (36-38 weeks) PNC visits Skilled delivery at birth EPI Childhood immunisation: e.g. Penta vaccine (6, 10 and 14 weeks) and Measles vaccine at 12 months	Increased rates of: timely introduction of BF within one hour of birth; exclusive breastfeeding (EBF) for 6 months; timely and appropriate complementary feeding (CF) at 6 months; dietary diversity (DD) at 12 months. EBF may reduce rates of infection and disease, boost immune function, improve mother-infant bonding, reduce risk of undernutrition. Optimal CF practices reduce the risk of undernutrition Increased DD provides more nutrients to support optimal growth and development, and a stronger immune system, reducing the risk of malnutrition and infections.	Health workers may lack the required counselling skills (*mitigation = MIYCAN Somalia training*) Additional workload for health workers should be assessed and monitored to ensure the quality of other services is not compromised (e.g. a reduction in the number of immunisations administered).
Include **nutritional screening of mothers and infants** in facility-level programmes.	ANC visits 1-4 PNC visits	Earlier detection of maternal undernutrition allows for timely interventions to improve maternal nutrition status, support healthy foetal development, reduces the risks of complications during pregnancy and childbirth and reduces the incidence of LBW.	Earlier identification of all forms of undernutrition has the potential to reduce the progression to more serious forms or outcomes of malnutrition (e.g. poor growth → wasting) and therefore may reduce the burden on health services. Additional workload for health workers should be assessed and monitored to ensure the quality of
	EPI Childhood immunisation: e.g.	Earlier identification of infants at risk of poor growth and development lowers the risk of wasting.	

[4] https://www.who.int/publications/i/item/9789241515856

	Penta vaccine at 6, 10 and 14 weeks		other services is not compromised (e.g. a reduction in the number of immunisations administered)
	EPI Childhood immunisation: e.g. Measles vaccine at 12 months	Earlier identification of child wasting lowers the risk of complications and could result in improved health outcomes. Increased screening coverage, which can increase the number of children with wasting identified and referred to the appropriate level of care.	
Include **nutrition interventions and counselling** for PBWG in facility-level programmes e.g. ANC and PNC	ANC visits 1-4 PNC visits EPI Childhood immunisation: e.g. Penta vaccine at 6, 10 and 14 weeks and Measles vaccine at 12 months	Provision of supplementation (MMS, IFA, Vit A), deworming and nutrition counselling during pregnancy and/or lactation reduces the risk of pregnancy complications, LBW and maternal undernutrition, breaking the cycle of malnutrition.	Health workers may lack the required counselling skills (*mitigation = MIYCAN Somalia training*) Additional workload for health workers should be assessed and monitored to ensure the quality of other services is not compromised (e.g. a reduction in the number of immunisations administered)

Table 1: Nutrition Integration Actions

Additional Integrated Actions that should be taken into consideration but are not within the scope of this training include:

- Add nutrition interventions to the job descriptions and task lists of health workers.
- Incorporate nutrition into national pre-service trainings and academic curricula for health workers (e.g. medical, nursing and midwifery schools)
- Ensure that management teams are trained to support health workers who deliver nutrition services at the facility level (e.g. training in supportive supervision, routine performance monitoring and standard operating procedures).
- Collection of nutrition indicators within existing government-managed health information systems (e.g. DHIS).
- Adequate consideration of nutrition services within annual budgeting processes (including supplies and operational costs).

Table 2 outlines the integration of key nutrition actions into broader health programming, with a focus on the core Modules included in the ToT.

Maternal and Adolescent Nutrition	
Rationale for Integration	Maternal nutrition interventions improve birth outcomes and reduce maternal and neonatal health risks. Achieving optimal maternal nutrition is recognised as one of the most effective interventions to reduce undernutrition and improve health across generations.[5]
Key Points of Integration	- ANC and childhood immunisation visits to screen for malnutrition using BMI or MUAC. - Individualised nutrition counselling and supplementation during routine ANC and PNC visits, and childhood immunisation. - Link high-risk cases to specialised care or community support.
Process of Integration	- Train health workers on maternal and adolescent nutrition counselling and monitoring. - Incorporate nutrition screening (BMI, MUAC) into ANC, PNC, immunisation and routine services for adolescents. - Update ANC protocols to include maternal and adolescent nutrition as a core component. - Improve programme guidance to clarify the protocols for MMS within ANC provision.[6] - Include nutrition commodities in health supply inventories. - Stabilise supply issues (MMS, IFA, etc) through support for buffer stocks at the facility level. - Support greater demand among women and adolescents through increased community mobilisation and improved access to ANC services. [7] - Link women, families and adolescents to social protection programmes (e.g. cash transfers and/or school meal programmes). - Monitor and evaluate the impact of integrated services.
Tools and Examples	- MUAC tapes and BMI calculator. - Maternal/adolescent nutrition counselling cards for health workers. - Micronutrient supplementation protocols.

[5] Maternal and child nutrition. Lutter, Chesser K et al. The Lancet. 2013; 382(9904):1550-1551.

[6] Multiple Micronutrient Supplements in Humanitarian Contexts: Somalia Case Study. Emergency Nutrition Network (ENN): Kidlington, Oxford, UK. February 2024. http://doi.org/10.6084/m9.figshare.25134521

[7] In Somalia, utilisation of ANC services is very low; an average of 26.0% of pregnant women receive at least one ANC visit during their pregnancy (Source: Central African Journal of Public Health 2020; 6(6): 320-5). ANC care coverage is only 24% (Source: WHO RMNCAH policy brief, Somalia, September 2023).

	- Maternal nutrition counselling checklist[8]. - Key messages poster to display in HF to reinforce maternal nutrition priorities. - Case studies from similar settings demonstrating the impact of maternal / adolescent nutrition integration.
Infant and Young Child Feeding	
Rationale for Integration	Robust IYCF practices, including breastfeeding and complementary feeding, are essential for optimal growth, cognitive development, and reducing child mortality. Achieving optimal IYCF behaviours is recognised as one of the most effective interventions to reduce undernutrition, child mortality and disease.[9] The integration of IYCF into health services ensures that caregivers receive consistent, evidence-based support to adopt these practices.
Key Points of Integration	- ANC: Educating mothers about the benefits of breastfeeding. - PNC: Promoting exclusive breastfeeding for the first six months. - Growth monitoring sessions: Counselling on complementary feeding practices starting at 6 months.
Process of Integration	- Train health workers on IYCF counselling techniques and referral process for SAM. - Incorporate IYCF into routine immunisation, ANC and PNC visits. - Establish community-based support groups for breastfeeding mothers. - Develop referral systems for lactation challenges.
Tools and Examples	- IYCF Counselling Cards for health workers. - Checklist for BF support during ANC and PNC visits. - Key messages poster to display in HF to reinforce IYCF priorities. - Case study from similar setting demonstrating the impact of IYCF practices.
Growth Monitoring and Promotion	
Rationale for Integration	Regular growth monitoring identifies children at risk of malnutrition early, enabling timely interventions. Integrating GMP into routine health services strengthens efforts to prevent stunting, wasting, and underweight, supporting overall child health and development.
Key Points of Integration	- Routine immunization visits: Combining weight and height checks with vaccination appointments. - Community health programs: Monthly growth monitoring sessions.

[8] https://www.unicef.org/media/114566/file/Maternal%20Nutrition%20Counselling%20Brief.pdf

[9] Maternal and child nutrition. Lutter, Chesser K et al. The Lancet. 2013; 382(9904):1550-1551.

	- Health education sessions: Providing caregivers with actionable advice on child nutrition and feeding.
Process of Integration	- Train health workers to accurately measure and interpret growth data (weight, height, MUAC). - Incorporate GMP into standard operating procedures for child health clinics. - Use growth charts to engage caregivers and provide tailored nutrition advice. - Establish referral pathways for children showing signs of malnutrition. - Link at risk children and their families to food assistance or livelihood programmes.
Tools and Examples	- Growth charts and MUAC tapes. - SOPs for integrating GMP into immunisation services. - Poster to display in HF to reinforce GMP priorities. - Case study from similar setting.

Table 2: Nutrition Integration into Health Programming

Additional areas for integration into wider health programming, beyond the scope of this training, include WASH, Social Protection, and Food Security and Agriculture as they address the underlying determinants of malnutrition. *Table 3* outlines how these three key areas can be integrated into health programming.

Food Security and Agriculture	
Rationale for Integration	Food security and agriculture play a critical role in improving nutrition by ensuring access to diverse, nutrient-rich foods. Integrating these aspects into health programming helps address the root causes of malnutrition, such as poor dietary diversity and limited food availability, while empowering communities to achieve sustainable nutrition outcomes.
Key Points of Integration	- Community health programs: Collaborate with agriculture extension services to promote household food production, such as kitchen gardens and small livestock farming. - School health programs: Link nutrition education with school gardening initiatives to encourage healthier dietary practices. - Align nutrition interventions with food security programs, such as food distribution or cash-for-work schemes.
Process of Integration	- Collaborate with agriculture experts to develop community programs promoting nutrient-rich food production and consumption. - Advocate for policies that align agriculture and health goals to enhance community food systems. - Incorporate nutrition-sensitive approaches into existing food security programs to target vulnerable groups, such as pregnant women and young children.

Tools and Examples	- Case study: e.g. Improving household nutrition through kitchen garden / small scale production initiatives.
Social Protection	
Rationale for Integration	Social protection programs, such as cash transfers, food assistance, and safety nets, help reduce food insecurity and improve access to essential health and nutrition services. By targeting vulnerable populations, these interventions address the socioeconomic barriers to achieving optimal nutrition, particularly for women, children, and adolescents.
Key Points of Integration	- ANC and PNC: Identification of eligible women, adolescents and families for referral to social protection programs. - Growth monitoring sessions: Link at risk children and their families to food assistance or livelihood programmes - Raise awareness in communities of available social protection services and their benefits. - Coordinate with humanitarian social protection initiatives to ensure nutrition-sensitive approaches.
Process of Integration	- Train health workers to identify families in need of social protection services and to provide referrals. - Incorporate social protection awareness into health education sessions during ANC, PNC, and immunization visits. - Collaborate with social welfare agencies to ensure alignment between health and social protection objectives. - Advocate for nutrition-sensitive social protection policies that prioritize vulnerable groups, such as pregnant women and malnourished children.
Tools and Examples	- Referral forms for linking families to social protection programs. - Monitoring tools to track the impact of social protection on nutrition outcomes. - Case study: e.g. Successful implementation of nutrition-sensitive cash transfer programs in similar settings.
WASH	
Rationale for Integration	Poor WASH practices contribute to diarrhoea, intestinal infections, and other diseases that exacerbate malnutrition. Integrating WASH into health services helps prevent these conditions, improving the effectiveness of nutrition interventions and promoting overall health and resilience.
Key Points of Integration	- ANC and PNC: Health workers educate caregivers on handwashing, safe water handling, and hygienic food preparation. - Routine immunization: Incorporate WASH messaging and demonstrations into routine health activities. - Community health programmes: Promote WASH practices, such as building latrines and safe water storage - GMP: Discuss the importance of clean water and sanitation in preventing infections.
Process of Integration	- Train health workers to deliver WASH messages alongside nutrition counselling. - Develop health facility protocols that include WASH-focused discussions during routine visits.

	- Collaborate with WASH programs to ensure access to clean water and sanitation facilities in communities served by health facilities. - Include WASH indicators in nutrition programme monitoring to measure impact on health outcomes.
Tools and Examples	- WASH-related checklists for use during ANC and child health visits. - Handwashing demonstration kits for health workers. - WASH counselling cards and posters. - Case study: e.g. Integrating WASH and nutrition in a community health programme.

Table 3: Integration of Food Security and Agriculture, Social Protection and WASH into health programming

The Pedagogy of Adult Learning

Adults bring their own experiences, preferences, and motivations to the learning process. Understanding the principles of adult learning can help you be a more effective trainer:

- **Relevance:** Adults need to see the value in what they are learning. Clearly linking training content to their roles as health workers will make the material more meaningful.
- **Experience-Based Learning:** Adults bring their own knowledge and experiences into the training. Use this by encouraging participants to share their experiences and relate them to the new content.
- **Self-Direction:** Adult learners prefer to take an active role in their own learning. Allow room for discussion, questioning, and problem-solving within the training.
- **Practical Application:** Adults are motivated to learn things that will help them solve real-life problems. Relate the Modules to situations faced by health workers, asking them to share their experiences.

The Role of the Trainer

As a trainer, you are more than just a source of information, you are a facilitator of learning and change. A facilitator needs to be familiar with the material being taught; it is the facilitator's responsibility to provide explanations, conduct demonstrations, answer questions, conduct role plays, lead group discussions, and give participants the help they need to successfully complete the training.

Your role as trainer involves:

- **Delivering Content Effectively:** Present the training material in a clear and engaging manner, ensuring that key concepts of nutrition integration are understood.
- **Adapting to Your Audience:** Tailor the training to meet the specific needs and understanding of your participants, using your experience to make the content relevant and applicable.
- **Fostering Participation:** Encourage active engagement through discussions, practical exercises, and real-life case studies, allowing participants to learn by doing and share their own experiences.
- **Supporting Behaviour Change:** Guide participants in applying the training to their day-to-day work, helping them to develop practical skills and strategies for integrating nutrition into health services.

Facilitating the Training

This course covers a lot of information in a fairly short period of time. Additionally, the course employs a variety of training methods including theory, practical exercises and group discussions. You, the trainer, need to convey the material in a manner that is engaging, participatory, demonstrative and affirming. As a trainer, you will play a pivotal role in not only delivering content but also inspiring and equipping health workers to recognize the importance and value of nutrition integration at health facilities.

As facilitator you must plan ahead to ensure that training resources are available, the agenda is adhered to with activities started at the planned time, the participants are motivated and obstacles to learning mitigated (no phones ringing, appropriate breaks, etc). Additionally, it is your responsibility to monitor the progress of each participant and offer additional support if required.

Encourage participants to share their experiences. However, keep in mind that the time is limited and ensure that discussions are relevant to the topic and helpful to the group. Concentrate on covering the topics that apply to most women and infants rather than spending a long time discussing unusual or rare situations. If participants are looking for more information, direct them to more specialised training courses.[10]

[10] Training offered by UNICEF includes MIYCAN/IYCF counselling, Harmonised CHW training, IMAM training and SC training.

Action Planning

If time permits, facilitators may include a short action planning session at the end of the training. The purpose of this session is to support participants to translate learning into practice by developing a simple, feasible plan to cascade the training within their districts. During the pilot delivery of this training, participants reported that this session was particularly useful in clarifying next steps and strengthening confidence to apply and share the learning on return to their districts. Facilitators should guide participants to consider who will be trained, what key content will be prioritised, where and when training or mentoring will take place, and how activities can be integrated into existing supervision, monitoring, or coordination mechanisms. Facilitators are encouraged to highlight realistic goals and prioritise actions that can be implemented within existing roles and available resources.

KEY RESOURCES:

- UNICEF IYCF Counselling Cards, Somalia (English), Counselling Cards Somali
- UNICEF IYCF Counsellors Book Part 1: Key Practices, Somalia (English), Part 1 Somali
- UNICEF IYCF Counsellors Book Part 2: Technical Notes
- Somalia IMAM Guidelines, 2025 (revised)
- Somalia MIYCAN Guidelines, 2026
- IYCF Counselling: an integrated course: course handouts, WHO, UNICEF 2021 (job aids)

FACILITATOR GUIDE

Introduction to the Training

Learning Objectives

1. Introduce facilitators, participants and get to know each other
2. Discuss the participants' expectation of the training and outline the training objectives, clarifying the priorities and focus areas of the training course. Establish group norms.
3. Identify participant strengths and weaknesses in MIYCAN

MATERIALS:

- Flip chart papers and stand, markers
- Name tags
- Participant folders
- Training schedule (participant copy)
- Pre-Training Assessment (*Annex 1*)

PREPARATION:

- Flip chart: course objectives
- Pre-Training Assessment codes assigned to participants
- Print training schedule and pre-training assessment for each participant

DURATION: 60 minutes

Session 1: Introductions, training expectations and objectives. Pre-Training Assessment.

Session Objectives 1 and 2: Introduce facilitators, participants and get to know each other.
Discuss the participants' expectation of the training and outline the training objectives, clarifying the priorities and focus areas of the training course. Establish group norms.

Activities

1. Ask the participants to introduce themselves briefly to the group and name one expectation for the training.
2. Divide the participants into small groups and ask them to brainstorm group norms for the training. List the norms on the flip chart and keep the list visible on a wall throughout the training.
3. Introduce the training objectives and compare them with the expectations of the participants.

FACILITATOR NOTES: While the expectations and group norms should be generated by the group, it will be useful to include the following items on the lists:

EXPECTATIONS:

- The training will include both technical knowledge and practical exercises
- There will be time for review and questions
- The training will be conducted in the spirit of a learning environment
- Individuals will be required to demonstrate competency in the subject matter

GROUP NORMS:

- Individuals will be prompt, engaged and prepared for training
- There will be mutual respect among all individuals engaged in the training
- Mobile phones will not be used during the training
- Sessions will be completed in a timely manner

Session Objective 3: Participants' strengths and weaknesses identified in MIYCAN and its integration at the health facility

Activity: Written pre-assessment	1. Distribute participant copies of the Pre-Training Assessment (*Annex 1*) to the participants and ask them to complete the test individually. 2. Ask participants to write their code number (previously assigned) on the pre-training assessment (participants use the same number for the post-training assessment). 3. Mark the tests as soon as possible, noting topics that need to be addressed. Keep a note of the scores to compare with the post-training assessment results.

Facilitator's copy Pre-Training Assessment: What do we know now?

Qu.	Statement	Yes	No	Don't Know
1	Nutrition counselling of pregnant and lactating women should take place at each visit with a health worker.	x		
2	I feel confident in my ability to advise a pregnant woman about nutrition during ANC visits.			
3	The amount and types of food a woman eats during pregnancy can affect a baby's health.	x		
4	Poor child feeding during the first 2 years of life harms growth and brain development.	x		
5	An infant aged 6 to 9 months needs to eat at least 3 times a day in addition to breastfeeding.		x	
6	A pregnant woman needs to eat additional, nutritious food each day.	x		
7	Telling a mother how to feed her child is the most effective way of changing her infant feeding practices.		x	
8	The more milk a baby removes from the breast, the more breast milk the mother makes.	x		
9	Suboptimal breastfeeding practices are linked to infant mortality.	x		
10	During the first 6 months, a baby living in a hot climate needs water in addition to breast milk.		x	
11	A young child (aged 6 to 24 months) should not be given animal foods such as eggs and meat.		x	
12	A newborn baby should always be given colostrum (the first thick, yellowish breast milk).	x		
13	Pregnant and/or lactating adolescents require the same amount of food as a fully developed PL woman.		x	
14	Nutrition interventions should be included at each health service contact point with women, adolescents, infants and children.	x		
15	Severe iron deficiency may lead to anaemia, spontaneous abortion or low-birth-weight.	x		
16	It is only important to monitor the weight of the child, not of the mother.		x	
17	Pregnant and lactating women are at greater risk of undernutrition than other groups in the population	x		

18	One of the major causes of low-birth-weight is maternal malnutrition.	x		
19	Growth monitoring and promotion at health service contact points plays an important role in the reduction of wasting.	x		
20	Assessing the growth of the child is sufficient to improve child health.		x	

Module 1 - Integrating nutrition at key contact points at the health facility

Module 1 Learning Objectives

Participants understand which key nutrition interventions and messages should be applied at each contact point between health workers and target groups (women, adolescent girls, infants, and young children) at the health facility. Participants know how to effectively leverage these contact points to integrate nutrition into health services.

MATERIALS:

- PPT slides 2 and 3: Module 1 Integrating nutrition at key contact points at the health facility
- Matching activity facilitator checklist
- Nutrition Integration Checklist
- Participant copies of Session 2 Matching Grid (blank)
- Handout/Job Aid: Rapid Screening Guide for mother-infant pair

PREPARATION:

- PPT slides 2 and 3: Module 1 Integrating nutrition at key contact points at the health facility
- Print copies of Nutrition Integration Checklist
- Print copies of Session 2 Matching Grid (blank)
- Print copies of Rapid Screening Guide for mother-infant pair (*Annex 7*)

DURATION: *Session 2* - Matching Activity 75 minutes

Session 2: Linking health service contact points to nutrition counselling and interventions

Session 2 Objective: Participants understand how the key contact points at the health facility can be leveraged for nutrition counselling and interventions and which nutrition messages / interventions should be applied at each contact point.

Session 2	
Slides	Present Module 1 slides 2 and 3, outlining to the participants the benefits of each integrated action. Provide some time for Q&A.
Matching activity *(75 mins)*	Matching the correct nutrition interventions and messages to each health service contact point: a. In plenary ask participants to suggest relevant contact points at which nutrition interventions could be applied. Ask if they currently integrate any nutrition interventions and if so, which ones. Ask what resources if any they currently use to support the nutrition interventions. Ask why nutrition interventions are important. Use *Tables 1 and 2* (Nutrition Integration Actions) to explain the key actions and why they are important. b. Divide participants into 4 groups. Distribute a copy of the Nutrition Integration Checklist to each participant, and a copy of the Session 2 Matching Grid (blank) to each group. c. Explain that the aim of the activity is for participants identify which nutrition messages and interventions (e.g. IFA supplementation) should be applied at each contact point with mothers and infants at the health facility, and the resources that can support them to do this. d. Ask the groups to take the time to go through each of the contact points with mothers/caregivers and infants at the health centre one by one. For each contact point they should identify the key messages, resources and interventions they will need to

integrate nutrition into the visit. One person in each group should be nominated as note-taker and should complete the matching grid for each contact point. Allow 30 minutes.

e. Bring the group back to plenary. Ask one person from each group to present the resources, interventions and key messages identified for each contact point. Ask the other groups to contribute if any are missing. Guide the participants if resources and materials have been missed (Refer to facilitator copy of Matching Grid). Continue going round the groups until each contact point has been covered.

f. Q&A session.

Nutrition Integration Checklist

Checklist: Nutrition Integration for Health Workers at Health Facilities – Key nutrition messages and interventions for each contact point with mothers and infants.

1st ANC visit (8-12 weeks of pregnancy)[11]	☐MMS or ☐Iron and folic acid (IFA) supplementation[12] ☐MUAC screening ☐Routine monitoring of weight – calculate BMI for baseline ☐Counselling on healthy eating and physical activity during pregnancy
2nd ANC visit (24-26 weeks of pregnancy)	☐Deworming[13] ☐Verify MMS supplies and adherence ☐Verify IFA supplementation supplies and adherence ☐MUAC screening ☐Routine monitoring of weight gain ☐Counselling on healthy eating and physical activity during pregnancy
3rd ANC visit (32 weeks of pregnancy)	☐Verify MMS supplies and adherence ☐Verify IFA supplementation supplies and adherence ☐MUAC screening ☐Routine monitoring of weight gain ☐Counselling on healthy eating and physical activity during pregnancy
4th ANC visit (36-38 weeks of pregnancy)	☐Verify MMS supplies and adherence ☐Verify IFA supplementation supplies and adherence ☐MUAC screening ☐Routine monitoring of weight gain ☐Counselling on healthy eating and physical activity during pregnancy ☐BF counselling in preparation for birth
Skilled Delivery at Birth	☐Early initiation of breastfeeding, skin-to-skin contact, exclusive breastfeeding, rooming-in, responsive on-demand feeding ☐BF counselling and support

[11] As per WHO FANC model for recommended timing and frequency of ANC visits.

[12] As per protocols, *either* MMS *or* IFA should be administered.

[13] Note: do not give deworming medication to pregnant women in the first trimester.

PNC visits	☐Rapid screening of mother infant pair[14] ☐BF counselling and support. ☐IYCF: exclusive breastfeeding to 6 months ☐IFA supplementation for the mother (3 months postpartum) ☐Verify MMS supplies and adherence for mother ☐Growth monitoring and promotion
Childhood Immunisation: Penta vaccine 1st dose (6 weeks)	☐BF counselling and support. *Note:* coincides with the 6-week growth spurt in infants. Explain that the infant may want to feed more often during this growth spurt. ☐IYCF: exclusive breastfeeding to 6 months and timely introduction of appropriate complementary foods at 6 months, with continued BF to 24 months ☐Rapid screening of mother-infant pair ☐IFA supplementation for the mother (3 months postpartum) ☐Verify MMS supplies and adherence for mother ☐Growth monitoring and promotion
Childhood Immunisation: Penta vaccine 2nd dose (10 weeks)	☐BF counselling and support. Advise mother/caregivers of the second growth spurt at around 3 months. Remind the mother that the infant may want to feed more often at this time. ☐IYCF: exclusive breastfeeding to 6 months and timely introduction of appropriate complementary foods at 6 months, with continued BF to 24 months ☐IFA supplementation for the mother (3 months postpartum) ☐Verify MMS supplies and adherence for mother ☐MUAC Rapid screening of mother-infant pair ☐Growth monitoring and promotion
Childhood Immunisation: Penta vaccine 3rd dose (14 weeks)	☐BF counselling and support. *Note:* coincides with the 3-month growth spurt in infants. Explain that the infant may want to feed more often during this growth spurt. ☐IYCF: exclusive breastfeeding to 6 months and timely introduction of appropriate complementary foods at 6 months, with continued BF to 24 months ☐ Rapid screening of mother-infant pair ☐Verify MMS supplies and adherence for mother to 6 months postpartum ☐Growth monitoring and promotion
Childhood Immunisation: Measles vaccine (12 months)	☐BF: remind the mother/caregiver that one third of the child's energy needs between 12 and 24 months should come from breastmilk. ☐IYCF: varied diet, appropriate and timely introduction of complementary foods ☐Vitamin A ☐MUAC: mother <21cm = referral ☐Growth monitoring and promotion ☐Family Planning

Figure 1: Checklist: Nutrition Integration for Health Workers at Health Facilities – Key nutrition messages and interventions for each contact point with mothers and infants.

[14] See Rapid Screening Guide

Matching Grid – Participant Copy (Blank)

Contact Point	Resources	Interventions	Key Messages
1st ANC visit (8-12 weeks of pregnancy)			
2nd ANC visit (24-26 weeks of pregnancy)			
3rd ANC visit (32 weeks of pregnancy)			
4th ANC visit (36-38 weeks of pregnancy)			
Skilled Delivery at Birth			
PNC visits			
Childhood Immunisation: Penta vaccine 1st dose (6 weeks)			
Childhood Immunisation: Penta vaccine 2nd dose (10 weeks)			
Childhood Immunisation: Penta vaccine 3rd dose (14 weeks)			
Childhood Immunisation: Measles vaccine (12 months)			

Figure 2: Matching Grid - Participant Copy

Matching Grid – Facilitator Copy (Filled)

Contact Point	Resources	Interventions	Key Messages
1st ANC visit (8-12 weeks of pregnancy)	Counselling cards on maternal nutrition in pregnancy	MMS/ Iron and folic acid, BMI calculation, MUAC Counselling on healthy eating and physical activity during pregnancy	The importance of eating a balanced diet The importance of taking MMS or IFA supplements Appropriate weight gain during pregnancy
2nd ANC visit (24-26 weeks of pregnancy)	Counselling cards on maternal nutrition in pregnancy Counselling cards on breastfeeding	MMS/ Iron and folic acid, weight gain monitoring, MUAC Deworming Counselling on healthy eating and physical activity during pregnancy	The importance of eating a balanced diet The importance of taking MMS or IFA supplements Appropriate weight gain during pregnancy
3rd ANC visit (32 weeks of pregnancy)	Counselling cards on maternal nutrition in pregnancy Counselling cards on breastfeeding	MMS/ Iron and folic acid, weight gain monitoring, MUAC Counselling on healthy eating and physical activity during pregnancy	The importance of eating a balanced diet The importance of taking MMS or IFA supplements Appropriate weight gain during pregnancy
4th ANC visit (36-38 weeks of pregnancy)	Counselling cards on maternal nutrition in pregnancy Counselling cards on breastfeeding Counselling cards on maternal nutrition for lactation	MMS/ Iron and folic acid, weight gain monitoring, MUAC Counselling on healthy eating and physical activity during pregnancy BF counselling in preparation for birth	Preparation for BF
Skilled Delivery at Birth	Counselling cards on maternal nutrition for lactation MAMI cards	BF Counselling Rooming-in Responsive on-demand feeding Skin-to-skin contact	Initiation of BF within 1 hour of birth Importance of colostrum
PNC visits	Counselling cards on maternal nutrition for lactation Counselling cards on breastfeeding	BF Counselling Rapid screening of mother-infant pair MMS – verify adherence and supplies	Exclusive BF to 6 months, timely introduction of appropriate complementary feeding at 6 months and

	MAMI cards and MAMI Care Pathway Rapid Screening Guide		continued BF to 24 months
Childhood Immunisation: Penta vaccine 1st dose (6 weeks)	Counselling cards on maternal nutrition for lactation Counselling cards on breastfeeding MAMI Cards and MAMI Care Pathway Rapid Screening Guide	GMP (+ screening) Rapid screening of mother-infant pair MMS – verify adherence and supplies BF counselling and support	The six-week Penta vaccination coincides with the 6-week growth spurt in infants. Explain that the infant may want to feed more often during this growth spurt. Exclusive BF
Childhood Immunisation: Penta vaccine 2nd dose (10 weeks)	Counselling cards on maternal nutrition for lactation Counselling cards on breastfeeding and complementary feeding MAMI cards and MAMI Care Pathway Rapid Screening Guide	GMP (+ screening) Rapid screening of mother-infant pair MMS – verify adherence and supplies	The 10-week Penta vaccination comes at the point of the second growth spurt at around 3 months. Remind the mother that the infant may want to feed more often at this time. Exclusive BF Importance of a healthy and adequate diet for BF
Childhood Immunisation: Penta vaccine 3rd dose (14 weeks)	Counselling cards on maternal nutrition for lactation Counselling cards on breastfeeding and complementary feeding MAMI cards and MAMI Care Pathway Rapid Screening Guide	GMP (+ screening) Rapid screening of mother-infant pair MMS – verify adherence and supplies	Exclusive BF Importance of a healthy and adequate diet for BF
Childhood Immunisation: Measles vaccine (12 months)	Counselling cards on maternal nutrition for lactation Counselling cards on dietary diversity and complementary feeding Counselling cards on GMP	GMP (+ screening) MUAC measurement of mother Deworming	Complementary Feeding Dietary diversity Remind the mother/caregiver that one third of the child's energy needs between 12 and 24 months should come from breastmilk

Figure 3: Matching Grid - Facilitator Copy

Module 2 - An Introduction to Nutrition

Module 2 Learning Objective

Participants understand key nutrition concepts and definitions, and the importance of nutrition in the first 1000 days.

MATERIALS:

- Flip chart, papers and stand, markers
- Laptop and projector
- Cards for Pile Sort Activity

PREPARATION:

- Activity 1 - Cards for Pile Sort Activity prepared (*Annex 2*)
- Activity 2 - Module 2 slides (see ToT Nutrition Integration, Somalia Slides)

DURATION: 105 minutes

- Session 3 - Group work and Discussion 60 minutes
- Session 4 -Theory and Q&A 45 minutes

RESOURCES:

- UNICEF IYCF Counselling Cards, Somalia (English), Counselling Cards Somali
- UNICEF IYCF Training Aids
- UNICEF IYCF Counsellors Book Part 1: Key Practices, Somalia (English), Part 1 Somali
- UNICEF IYCF Counsellors Book Part 2: Technical Notes
- Somalia IMAM Guidelines, 2025
- Somalia MIYCAN Guidelines, 2026
- UNICEF Conceptual Framework on Maternal and Child Nutrition

Sessions 3 & 4: Overview of key nutrition definitions and concepts

Session 3 & 4 Objective: Participants gain an understanding of key nutrition definitions, and the importance of nutrition in the first 1000 days.

Session 3 **Group work & discussion** *(60 mins)*	Pile-sort cards on **'An introduction to nutrition in the first 1000 days'** a. Explain that this activity will provide an opportunity to discuss why nutrition in the first 1000 days of life is so important. Ensure that participants are familiar with the first 1000 days being the period between conception and 2 years of age. b. Divide the participants into small groups and hand-out the materials for the pile-sort activity. Explain that each card has a different statement, and the group should determine whether the statement on the card is 'true' or 'false'. The groups should form 2 piles of cards – one for true and one for false statements. c. Instruct the groups to choose a volunteer to read each card and then decide as a group whether the statement is true or false. Repeat until all the cards have been discussed and placed in one of the 2 piles: True or False. d. Once all groups have completed the exercise, return to the whole group. Have 2 flip charts ready with TRUE written on top of one and FALSE written on top of the other.

	Starting with Statement 1, read each statement and ask one group per statement to share the answer they selected. If the answer is correct ask the volunteer to stick the card onto the corresponding flip chart. If there is disagreement, explain and reinforce the correct information. Complete all statements in this way until all the statement cards are displayed on the correct flip chart.
Session 4 **Theory** *(45 mins)*	Present slides Module 2: An Introduction to Nutrition. At the end of your presentation leave enough time for a Q&A session so that participants can clarify any of the points covered.

FACILITATOR NOTES:

The following messages relating to the first 1000 days should be emphasized during this activity:

- This is the time when the most critical brain and physical growth of the baby happens.
- Good health, nutrition, care practices, lifelong feeding and eating habits are very important during this period to ensure the baby grows and reaches its full physical and mental development. Food preferences and tastes are also established during the first two years and persist into later life.
- Insufficient energy and nutrient intake can begin in utero. It is critical that good nutrition for women begins before conception and continues throughout pregnancy.
- Weight-for-age data shows that growth faltering begins early, at about 3 months of age, with a rapid decline through 12 months. This pattern is common in all regions of the world.
- Infants <6 months with SAM are at a greater risk of morbidity and mortality compared to children >6 months.
- The window of opportunity for improving nutrition is small – from before pregnancy through the first 2 years of life (the first 1,000 days). Any damage to physical growth and brain development that occurs during this period is likely to be extensive and, if not corrected, may be irreversible.
- The effects of malnutrition (including child stunting and wasting) on mental and physical development contribute to poor productivity, low economic growth, and the continuation of poverty.

Facilitator copy: Pile Sort Activity – An introduction to nutrition in the first 1000 days

Qu.	Statement	True	False
1	Good maternal nutrition, health and physical status help to prevent low birth weight and subsequent stunting	x	
2	Pregnancy increases nutrient needs	x	
3	Pregnancy to 2 years old (the first 1000 days) is the most crucial time to meet a child's nutritional needs and address stunting	x	
4	A low-birth-weight baby / wasted / underweight infant is **not** more susceptible to communicable diseases than a normal weight infant		x
5	Poor growth can be aggravated by frequent incidence of infection diseases	x	
6	All the following practices can lead to poor growth after birth: inadequate breastfeeding practices, poor access to diverse types of food, inadequate intake of micronutrients	x	
7	Pregnancy in adolescence is not more likely to result in a low-birth weight baby		x
8	A stunted child will have a normal cognitive capacity		x
9	Breastfeeding is the most cost-effective intervention to reduce child mortality	x	

10	Micronutrient needs for iron, vitamin A and folic acid can always be met through the local diet		x
11	The short-term consequences of undernutrition are increased morbidity, mortality and disability	x	
12	The long-term consequences of undernutrition include reduced adult height, cognitive ability, economic productivity and increased risk of metabolic and cardiac disease	x	
13	The immediate causes of maternal and child undernutrition are inadequate dietary intake, disease and inadequate health services		x
14	Growth faltering usually begins at about 6 months of age, with a rapid decline through 12 months		x
15	The effects of malnutrition (including child stunting and wasting) on mental and physical development contribute to poor productivity, low economic growth, and the continuation of poverty	x	
16	Any damage to physical growth and brain development that occurs during the first 1000 days is likely to be extensive and, if not corrected, may be irreversible.	x	

Module 3 - Maternal and Adolescent Nutrition

Module 3 Learning Objectives

- Participants can list the recommended maternal and adolescent nutrition interventions for pregnancy and lactation.
- Participants can accurately calculate BMI.
- Participants can identify the appropriate maternal and adolescent nutrition interventions for each health service contact point.

MATERIALS:

- Laptop and projector
- Flipchart and markers
- Notepads and pens
- BMI worksheet (*Annex 4*)
- Facilitator's copy of the Maternal Nutrition Interventions at Health Service Contact Points grid (*Annex 4*)
- Participants' copy of Maternal Nutrition Interventions at Health Service Contact Points grid and Intervention Cards (*Annex 4*)
- Handout: Key content for the nutritional counselling of women and adolescent girls during preconception, pregnancy and preconception care[15] (Annex 4)

PREPARATION:

- Session 5 Activity 1: Module 3 slides 10 to 16
- Session 5 Activity 2: Draw the cycle of malnutrition on the flip chart (see *Figure 1*)
- Session 6 Activity 1: Module 3 slides 6 and 7
- Session 6 Activity 2: Print sufficient copies of the BMI worksheet (1 per participant)
- Session 6 Activity 3: Print sufficient copies of the Maternal Nutrition Interventions at Health Service Contact Points grid (participant's copy) and Intervention Cards (pre-cut cards)

DURATION: 120 minutes

- Session 5: Theory 15 minutes, Groupwork and Discussion 45 minutes.
- Session 6: Theory 15 minutes, Practical Exercise 20 minutes, Matching Activity 25 minutes.

RESOURCES:

- UNICEF IYCF Counselling Cards
- UNICEF IYCF Training Aids
- UNICEF IYCF Counsellors Book Part 1: Key Practices
- UNICEF IYCF Counsellors Book Part 2: Technical Notes
- Kangaroo Mother Care – WHO Guidance and NEST360 Toolkit
- Somalia Community IYCF Counselling Package 2026, Counsellor's Book Part 1: Key Practices
- Somalia National IMAM Guidelines, FMoH
- Maternal Nutrition Counselling Checklist, UNICEF 2022
- UNICEF Programming Guidance. Prevention of malnutrition in women before and during pregnancy and while breastfeeding.

[15] Counselling to Improve Maternal Nutrition, A Technical Brief, UNICEF 2022

Maternal nutrition interventions improve birth outcomes and reduce maternal and neonatal health risks

Session 5: Maternal Nutrition Interventions

Session 5 Objective: Participants gain an understanding of the package of maternal nutrition interventions and their role in improving maternal and adolescent nutrition during pregnancy and lactation. They will also recognise the importance of these interventions for maternal and child health outcomes.	
Session 5 **Theory** *(15 mins)*	Present Module 3 slides **10 to 16** on Maternal and Adolescent nutrition. At the end of your presentation leave enough time for a short Q&A session so that participants can clarify any of the points covered.
Session 5 **Groupwork & Discussion** *(45 mins)*	a. Explain the objective of the activity: to understand the role of maternal nutrition interventions in improving maternal and adolescent nutrition during pregnancy and lactation. b. Divide the participants into 4 groups and give each group a notepad and pen. The groups should each nominate a note-taker for this activity. c. Display the 'Cycle of Malnutrition' on the flip chart and remind participants how the cycle operates (*Figure* 4). d. Give the groups 10 minutes to discuss and note as many points as they can think of under the heading '*Actions to break the undernutrition cycle for adult women and adolescent girls*.' e. Bring the group back to plenary and ask each group in turn to share two noted points. Add these to the flip chart. Continue until all the points have been shared. f. Discuss the answers, adding any points that have been missed. g. Allow time for Q&A to clarify any points.

FACILITATOR NOTES:

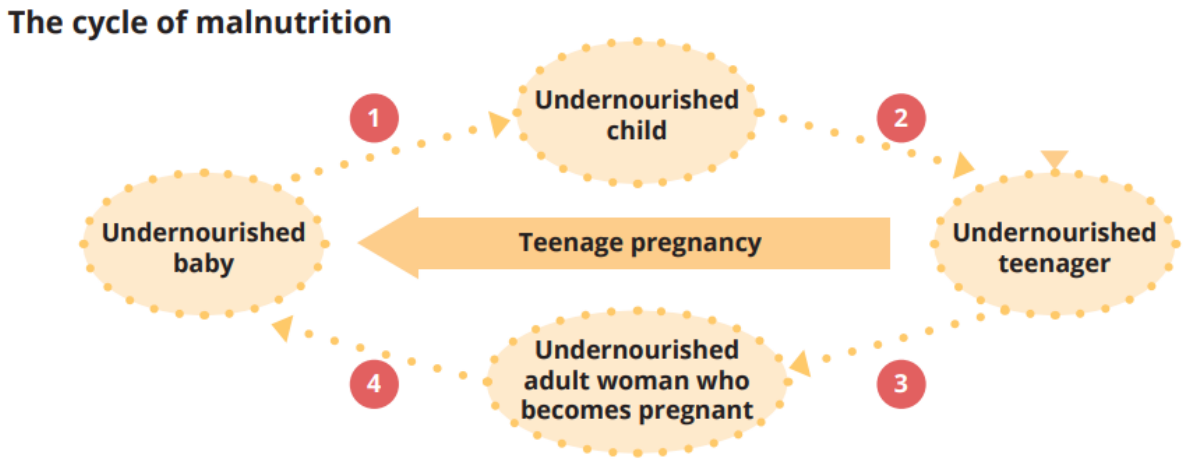


Figure 4: The cycle of malnutrition

- Nutrition counselling before and during pregnancy and lactation is a critical intervention in maternal and child health.

- Counselling should include decisions and actions on the types, diversity and amounts of food a pregnant or lactating woman/adolescent should eat to meet her dietary requirements. Pregnant and Breastfeeding Women and Girls (PBWG) should consume a variety of foods to improve dietary diversity and increase micronutrient adequacy. (See Figure 7).
- The adolescent age (10-19 years) is a critical phase in a girl's development. An adolescent mother needs extra care, more food and more rest than an older mother. The adolescent mother needs to nourish her own body, which is still growing, as well as her growing baby.
- It is important to screen and counsel all pregnant adolescents.
- First pregnancies should be delayed until growth is completed (usually 20-24 yrs).
- Healthy weight gain during pregnancy will reduce the risk of low-birth-weight infants in undernourished populations.
- Energy requirements in pregnancy increase by an average of 300 kcal/day while there is also an increased need for protein, vitamins and minerals such as iron, folic acid and calcium.
- During lactation, energy requirements are highest and increase by around 640 kcal/day.
- PBWG should consume extra food to meet increased energy requirements. This should come from nutrient-rich dishes and a diverse diet, including locally available and affordable nutritious foods and fortified foods (iodized salt, fortified vegetable oil and fortified cereals).
- Avoid drinking tea and coffee with or just after meals as this inhibits absorption of iron. Including foods rich in vitamin C in meals helps to improve iron absorption.
- Take adequate rest and avoid heavy workloads.
- Continued and consistent use of IFA is important for pregnant women to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth (see *Figure 5* and *Annex 3* - Protocol for Micronutrient Support).

Supplement Composition	Iron: 30-60 mg of elemental iron Folic Acid: 400 µg (0.4mg)
Target Group	All pregnant adolescents and women
Frequency	One supplement Daily
Duration	Throughout pregnancy and BF, starting as early as possible

Figure 5: Daily IFA supplementation in pregnant women and adolescents

As a preventive measure against multiple micronutrient deficiencies, PLW and adolescents should be provided with MMS (see *Figure 6* and *Annex 3 - Protocol for Micronutrient Support*).

Supplement Composition	Vitamin A, vitamin B1, vitamin B2, niacin, vitamin B6, vitamin B12, folic acid, vitamin C, vitamin D, vitamin E, copper, selenium, iodine; with 30 mg of iron and 15 mg of zinc
Target Group	All pregnant and lactating women
Frequency	One tablet daily
Duration	Pregnancy- Throughout pregnancy, starting as early as possible Lactation – until the infant is six months

Figure 6: Multiple micronutrient supplementation in pregnant and lactating women

Deworming to control intestinal parasites should be provided to pregnant women after the first trimester of pregnancy (see *Annex 3 - Protocol for Micronutrient Support*).

Food groups	Examples
Grain, grain products and other starchy foods	*Whole grains:* rice, maize, millet, sorghum, *Starchy roots*: white fleshed sweet potato, unripe bananas, arrowroots, cassava, yam among others *Products:* wheat flour, maize flour, spaghetti, Weetabix, cornflakes, porridge flours among others
Legumes /Pulses	Dried beans any variety, dried peas, cow peas, green grams, lentils among others
Nuts and seeds	Macadamia, peanuts/ ground nuts, cashew nuts, Baobab seeds, Simsim, pumpkin seeds, chia seeds, poppy seeds
Flesh foods	Red meat variety, white meat varieties, insects, canned meats
Eggs	Any type available and consumed by community
Dairy and dairy products	Fresh milk, processed milk, fermented milk, yoghurt, cheese
Green leafy vegetables	Any green vegetables available and consumed in the region
Other vitamin A rich fruits and Vegetables	Fruits: mangoes, pawpaw, purple skin passion fruit, peaches, loquats, yellow or orange fleshed sweet potatoes Vegetables: carrots, pumpkin
Other fruits	Ripe bananas, guavas white and red fleshed, tree tomatoes, watermelon red colour, oranges, pineapples, apples among others
Other vegetables	Tomatoes, Coriander, Capsicum, onions, cabbage, cucumber, green peas, green beans, green maize among others available in the market

Figure 7: Food groups for women and adolescents

Session 6: Maternal Nutrition Interventions and their Integration into ANC services

Session 6 Objectives:

- Participants understand healthy weight gain during pregnancy and how to measure this.
- Participants are able to identify the appropriate maternal nutrition interventions for each health service contact point.

Session 6 **Theory** *(15 min)*	Present Module 3 Slides **17 to 20:** *Healthy Weight Gain During Pregnancy; MUAC Screening of PLW; Enrolment of PBWG in the TSPF; Rapid Screening Guide.* At the end of your presentation leave enough time for a short Q&A session so that participants can clarify any of the points covered.
Session 6 **Practical Exercise -**	a. Introduce the Activity: Briefly explain the BMI formula and its purpose in determining nutritional recommendations for weight gain during pregnancy (see *Figure 9*).

Calculating BMI *(20 mins)*	b. Distribute the BMI Worksheet. Ask participants to calculate the BMI for each woman and classify it according to standard BMI categories (underweight, normal weight, overweight, or obese). c. Discussion and Review: After calculations, review the answers as a group and discuss any challenges. You can also ask participants to share how BMI would influence recommendations for each patient profile.
Session 6 **Matching Activity** *(25 mins)*	a. Explain the objective of the activity: to identify the appropriate maternal nutrition interventions for each contact point in health facilities. b. Divide the participants into 4 groups and give each group a participants' copy of the Maternal Nutrition Interventions at Health Service Contact Points grid and Maternal Nutrition Interventions Cards (see *Annex 4*). c. Ask the participants to work in their groups to complete the grid by matching the appropriate Maternal Nutrition Interventions Card to each health service contact point. d. Once the groups have completed the matching, share the correct Maternal Nutrition Intervention Card for each contact point, asking groups to raise their hands if they selected the correct card (refer to Facilitator's copy of the Maternal Nutrition Interventions at Health Service Contact Points grid, *Figure 11)*. e. Verify that the groups have now matched all the cards correctly and answer any questions that arise.

FACILITATOR NOTES:

Pregnant women should be encouraged to attend all ANC visits (note: The Somalia guidelines are in line with the WHO recommendation for 8 ANC visits[16]).

Weight Gain in Pregnancy:

Weight gain in pregnancy should take into consideration pre-pregnant body mass index (BMI) whenever possible.

To determine nutritional recommendations for weight gain during pregnancy, measure the woman's weight and height to calculate BMI (≤20 week's gestation).

Routine monitoring of weight gain at each ANC contact is important for assessing the progression of the pregnancy.

Gestational weight gain that is less than or greater than that recommended increases the risk of adverse maternal and infant outcomes (such as small-for-gestational-age or large-for-gestational age births, preterm births, macrosomia and caesarean delivery) and may also lead to postnatal weight retention.

Trimester	Weight gain per month
1st trimester	0.5 kgs per month
2nd trimester	1 – 1.5 kgs per month
3rd trimester	2 kgs per month

Figure 8: Recommended weight gain in pregnancy by trimester.

Source: Somalia MIYCAN Guidelines, 2023.

Nutritional status	Pre-pregnancy BMI or BMI ≤ 20 weeks gestation	Recommended weight gain
Underweight	< 18.5 kg/m2	12.5–18 kg
Normal weight	18.5–24.9 kg/m2	11.5–16 kg
Overweight	25–29.9 kg/m2	7–11.5 kg
Obese	> 30 kg/m2	5–9 kg

[16] WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience: Summary.

Figure 9: Recommended weight gain in pregnancy.

Source: Somalia MIYCAN Guidelines, 2023.

MUAC Screening of Pregnant and lactating Women:

Somalia has an objective of reducing the prevalence of wasting in pregnant and lactating women (MUAC <21 cm) by 10% by 2025[17].

Due to their additional nutritional needs, pregnant and lactating women may be at greater risk of undernutrition and underweight than other groups in the population.

MUAC is used to identify pregnant and lactating women who are underweight.

Low MUAC in pregnant women has been associated with intrauterine growth restriction, LBW and neonatal morbidity.

All pregnant and lactating women should be systematically screened for acute malnutrition and those whose MUAC is < 23cm should be referred for further nutritional support.[18]

As adolescents are at greater risk of being underweight due to the additional nutritional needs for their own growth and development, they should be routinely screened and provided with nutritional counselling and support.

Admission criteria	Category
MUAC <23.0 cm	Pregnant women/girls from 2nd trimester
	Breastfeeding women/girls with an infant <6 months

Figure 10: Enrolment criteria for PBWG in the TSFP.

Source: Somalia National Guideline on the Prevention and Management of Wasting and/or Nutritional Oedema, 2025.

Health Facility Contact Point	Maternal Nutrition Interventions
1st ANC visit (8-12 weeks of pregnancy)[19]	• MMS • Iron and folic acid supplementation • MUAC screening • Routine monitoring of weight – calculate BMI for baseline • Counselling on healthy eating and physical activity during pregnancy
2nd ANC visit (24-26 weeks of pregnancy)	• Deworming • Verify MMS supplies and adherence • Verify iron and folic acid supplementation supplies and adherence • MUAC screening • Routine monitoring of weight gain • Counselling on healthy eating and physical activity during pregnancy
3rd ANC visit (32 weeks of pregnancy)	• Verify MMS supplies and adherence • Verify iron and folic acid supplementation supplies and adherence • MUAC screening

[17] Ministry of Health and Human Services, Federal Republic of Somalia. *Somalia Nutrition Strategy 2020-2025.*

[18] Somalia National Guideline on the Prevention and Management of Wasting and/or Nutritional Oedema, 2025

[19] As per WHO FANC model for recommended timing and frequency of ANC visits.

	• Routine monitoring of weight gain • Counselling on healthy eating and physical activity during pregnancy
4th ANC visit (36-38 weeks of pregnancy)	• Verify MMS supplies and adherence • Verify iron and folic acid supplementation supplies and adherence • MUAC screening • Routine monitoring of weight gain • Counselling on healthy eating and physical activity during pregnancy • BF counselling in preparation for birth
Skilled Delivery at Birth	• Early initiation of breastfeeding, Kangaroo Mother Care, exclusive breastfeeding, rooming-in, responsive on-demand feeding • BF counselling and support
PNC visits	• Initial rapid screening of mother-infant pair • BF counselling and support • Verify MMS supplies and adherence for mother
Childhood Immunisation: Penta vaccine 1st dose (6 weeks)	• BF counselling and support (exclusive breastfeeding to 6 months) • Iron and folic acid supplementation for the mother (3 months postpartum) • MUAC: Initial rapid screening of mother-infant pair. Mother <23cm = enrol in TSFP • Verify MMS supplies and adherence for mother
Childhood Immunisation: Penta vaccine 2nd dose (10 weeks)	• BF counselling and support (exclusive breastfeeding to 6 months). Advise mother/caregivers of the second growth spurt at around 3 months. Remind the mother that the infant may want to feed more often at this time. • Iron and folic acid supplementation for the mother (3 months postpartum) • Verify MMS supplies and adherence for mother • MUAC: Initial rapid screening of mother-infant pair. Mother <23cm = enrol in TSFP
Childhood Immunisation: Penta vaccine 3rd dose (14 weeks)	• BF counselling and support (exclusive breastfeeding to 6 months). *Note:* coincides with the 3-month growth spurt in infants. Explain that the infant may want to feed more often during this growth spurt. • MUAC: initial rapid screening of mother-infant pair. Mother <23cm = enrol in TSFP • Verify MMS supplies and adherence for mother to 6 months postpartum
Childhood Immunisation: Measles vaccine (12 months)	• BF: remind the mother/caregiver that one third of the child's energy needs between 12 and 24 months should come from breastmilk. • IYCF: complementary feeding • MUAC: Initial rapid screening of mother-infant pair. Mother <23cm = enrol in TSFP • Family Planning

Figure 11: Facilitator copy: Matching Activity - Maternal nutrition interventions at health facility contact points

Module 4 - Infant and Young Child Feeding (IYCF): Breastfeeding

Module 4 Learning Objectives: Recommended Breastfeeding Practices

By the end of Module 4, participants are able to:

- Define exclusive breastfeeding, state the risks of NOT breastfeeding feeding, state the benefits of early initiation of breastfeeding and exclusive breastfeeding.
- Identify the recommended breastfeeding practices and describe the responsive care and feeding practices.
- Reflect on key time points for IYCF counselling and their links to key HS contact points.

MATERIALS:

- Flip chart, markers
- Laptop and projector
- Benefits of Breastfeeding to the Child, Mother, Family and Community/Society table
- Recommended Breastfeeding Practices cards (IYCF Training Aids, 2024)
- Key Time Points for Breastfeeding Counselling card (IYCF Booklet)
- Handout: Job aid – Postnatal contacts (Annex 5)

PREPARATION:

- Print Benefits of Breastfeeding to the Child, Mother, Family and Community/Society table (*Annex 5*) for each participant
- Module 4 slides (see ToT Nutrition Integration, Somalia slide deck)
- Prepare flip chart with grid for *Recommended Breastfeeding Practices* (*Figure 12*)
-

DURATION: 120 minutes

- Session 7: Theory 10 minutes, Groupwork and Discussion 50 minutes
- Session 8: Groupwork and Discussion 1 30 minutes, Groupwork and Discussion 2 20 minutes
- Session 9: Brainstorming 25 minutes

RESOURCES:

- UNICEF IYCF Counselling Cards
- UNICEF IYCF Training Aids
- UNICEF IYCF Counsellors Book Part 1: Key Practices
- UNICEF IYCF Counsellors Book Part 2: Technical Notes
- The Ten Steps to Successful Breastfeeding, UNICEF, WHO (Infographic)
- Somalia Community IYCF Counselling Package 2026, Counsellor's Book Part 1: Key Practices
- Somalia National IMAM Guidelines, FMoH
- MAMI Care Pathway Package
- IYCF Counselling: an integrated course: course handouts, WHO, UNICEF 2021
- Global Complementary Feeding Collective

Robust IYCF practices, including breastfeeding and complementary feeding, are essential for optimal growth, cognitive development, and reducing child mortality. The integration of IYCF into health services ensures that caregivers receive consistent, evidence-based support to adopt these practices

Session 7: Exclusive breastfeeding, risks of artificial feeding, early initiation of breastfeeding

Session 7 Objective: Participants are able to define exclusive breastfeeding, state the risks of artificial feeding, state the benefits of early initiation of breastfeeding and exclusive breastfeeding.

Theory *(10 mins)*	Present Module 4: Infant and Young Child Feeding **slides 21-24**
Group work & discussion: *(50 mins)*	a. Divide the participants into small groups. Ask them to discuss as a group and write 2-3 points for each of the following titles: Importance of breastfeeding to the infant, Importance of breastfeeding to the mother, Importance of breastfeeding to the family; Importance of breastfeeding to the community. Allow 30 minutes. b. Bring the group back to plenary to review the group work. Allow 20 minutes. c. Summarise the session and hand out copies of the '*Benefits of Breastfeeding to the Child, Mother, Family and Community/Society*' table for participants to add to their folder. d. Q&A session

Benefits to the Infant/ Child	Benefits to the Mother	Benefits to the Family	Benefits to the Community/ Society
• Breast milk contains antibodies that protects the infant/child from infectious diseases such as diarrhoea and respiratory infections • All the required nutrients are readily available at the right quantity and temperature • Breastmilk is easily digested hence nutrients are well absorbed • Protects against allergies. Breast milk antibodies protect the baby's gut preventing	• Promotes a quick recovery after delivery as it prevents heavy bleeding • Reduces risk of breast and ovarian cancers, heart disease and diabetes • Stimulates production of more breastmilk • Improves birth spacing if done exclusively for 6 months and amenorrhoea persists • Promotes bonding between mother and child	• Economical as no expenses involved in buying infant formula, firewood or other fuel, or utensils for the baby • Mothers and children are healthier, so medical costs are reduced • Promotes child spacing in families	• Economical as money is saved and used for other needs • Increased productivity in the society due to healthy and productive population • Savings in the health sector due to less illnesses in children • Improved child survival

harmful substances to pass into the blood • Provides adequate water needs for the baby (87% of water and minerals) • Helps jaw and teeth development; suckling develops facial muscles	• Reduces maternal workload (time taken to prepare feeds) as it is always available and in the correct temperature		• Does not generate waste/ pollute the environment

Table 4: Benefits of Breastfeeding to the Child, Mother, Family and Community Sources: MIYCAN Operational Programmatic Guideline, Somalia 2023. Somalia Harmonised CHW training manual, 2020

Session 8: Recommended breastfeeding practices, responsive care and feeding practices

Session 8 Objective: Participants are able to identify the recommended breastfeeding practices and describe the responsive care and feeding practices

Identify recommended breastfeeding practices through discussion *(30 mins)*	a. Divide participants into 4 groups and mention the specific objective. b. Provide participants with the ***IYCF Counselling Cards*** and the ***Counsellor's Book Part 1: Key Practices to*** help identify the recommended breastfeeding practices. c. Turn flip chart to the prepared *Recommended Breastfeeding Practices* graphic (based on *Figure 12* below). d. Give an example of a recommended breastfeeding practice (e.g., Place your baby skin-to-skin and initiate breastfeeding within the first hour of birth) and hold up the recommended practice word card showing immediate post-partum breastfeeding. Tape the written recommended practice to the top left quadrant of the graphic. e. Ask each group to review its ***Counselling Cards*** and identify the other recommended breastfeeding practices. Mention that there are at least eight other recommended breastfeeding practices. f. After 5 minutes, ask each group – one by one – to name one of the recommended breastfeeding practices that they found in their Counselling Cards. Ask groups not to repeat a practice that has already been shared. Continue rotating groups and probe until all the other eight practices have been identified. g. As each group presents its recommended breastfeeding practice, tape the word card of that practice on the graphic. (Use *Figure 13* below to guide placement of the words cards). h. After all nine recommended breastfeeding practices have been identified, read each practice out loud, and ask participants which Counselling Card or image from a Counselling Card corresponds with the recommended practices. i. As participants identify the Counselling Card or image from a Counselling Card, tape the corresponding image from ***IYCF Training Aids 6.2*** on top of the corresponding word card. j. Refer participants to the graphic in their ***Counsellor's Book Part 2***: Technical Notes 7.1: Recommended Breastfeeding Practices. Remind them that this is a job aid to help them remember which Counselling Cards and images can be used to promote each recommended practice. k. Summarize, correct points if needed, discuss, and fill in any gaps.
Overview of stomach size of newborn, Day 1, Day 3 and Day 7 *(5 mins)*	a. Demonstrate the size of a newborn stomach using your thumb and index finger, referring to *Figure 14* below. b. Put the index finger at the knuckle of the thumb. The circle formed is the size of the infant's stomach on Day 1. c. Demonstrate the size of the stomach on Days 3 and 7, referring to *Figure 14* below.

Describe responsive care and feeding practices *(20 mins)*	a. Ask each group to look for images of responsive care and feeding practices in the ***Counselling Cards***. b. Ask each group to present its findings and ask other participants to add any additional images or points. c. Refer to the **Counsellor's Book Part 2: Technical Notes 7.5:** Responsive Care Practices: Infants from Birth up to 6 Months of Age. d. Orient participants to the **Counsellor' Book Part 1: Key Practices** for all the **Counselling Cards** that have been discussed. e. e. Summarize, correct points if needed, discuss, and fill in any gaps.

FACILITATOR NOTES:

37% of babies delivered in health facilities in Somalia are not timely initiated to breastfeeding.[20]

Key clinical practices to support successful breastfeeding:

1. Discuss the importance and management of breastfeeding with pregnant women and their families.
2. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
3. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
4. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
5. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
6. Support mothers to recognize and respond to their infants' cues for feeding.
7. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
8. Coordinate discharge so that parents and their infants have timely access to ongoing support and care

Figure 12: Recommended breastfeeding practices graphic (empty)

[20] National Maternal, Infant, Young Child And Adolescent Nutrition Operational And Programmatic Guideline, Somalia, 2023

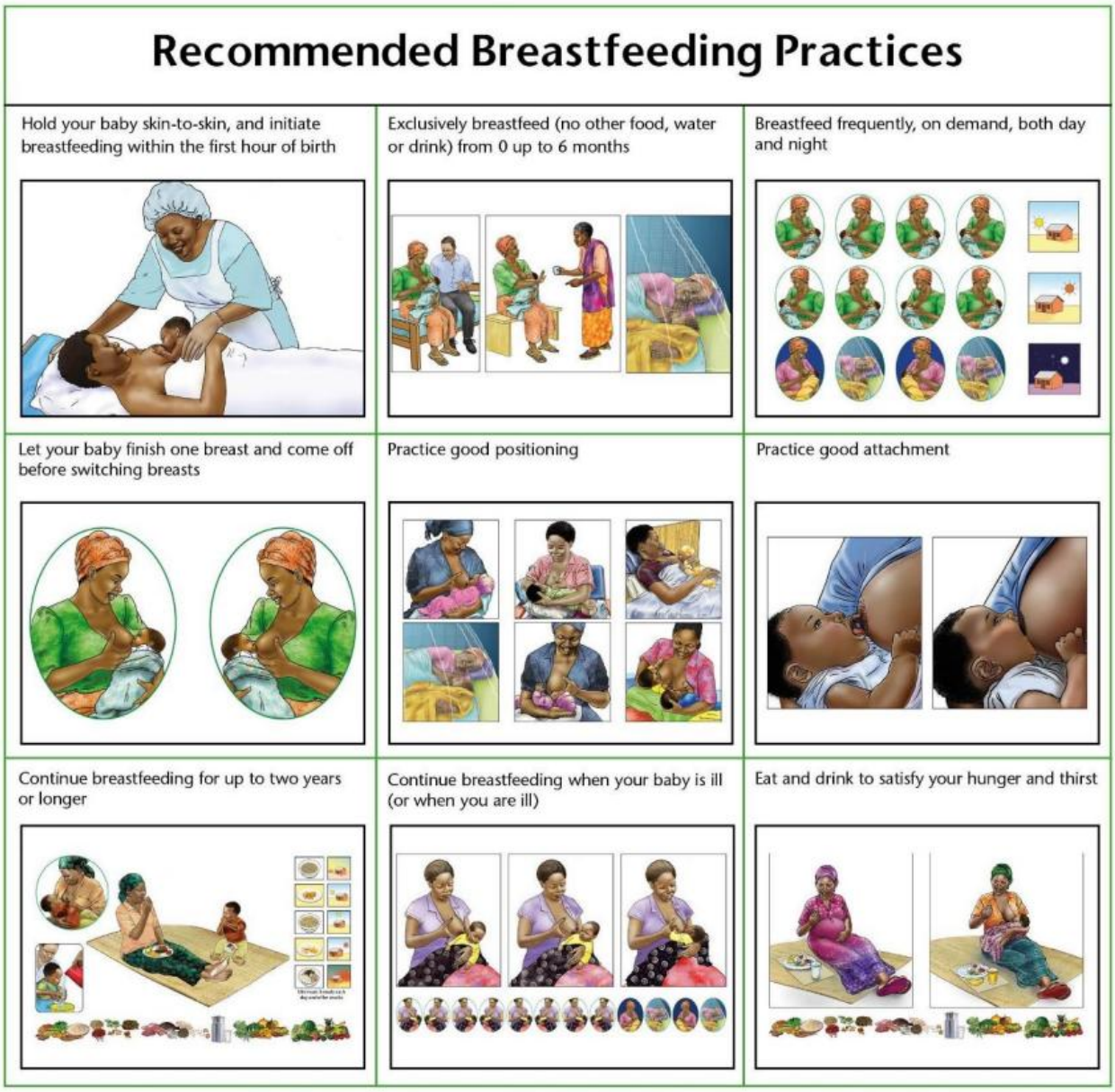


Figure 13: Recommended breastfeeding practices graphic (complete)

Size of stomach: Newborn, Day 3, and Day 7

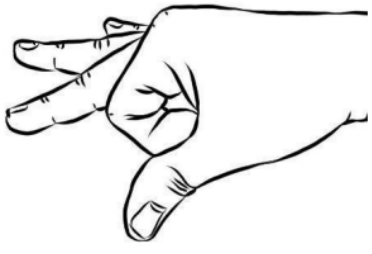
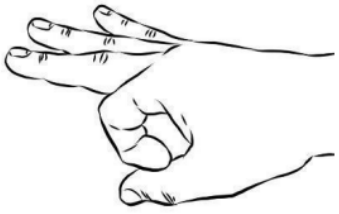
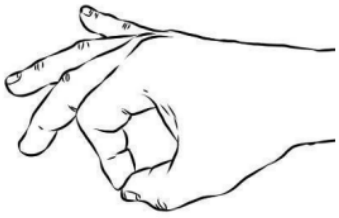
Newborn	Day 3	Day 7
		

Figure 14: Size of stomach: Newborn, Day 3, Day 7

Module 5 - IYCF: Timely introduction of appropriate complementary foods at 6 months

Module 5 Learning Objectives

By the end of Module 5, participants will be able to:

- State the benefits of continued BF for infants aged 6 to 24 months
- State the recommended complementary feeding practices, explain the risks associated with late or early introduction of complementary feeds, and describe the energy requirements for complementary feeding from 6-24 months
- Describe active and responsive feeding
- Understand the importance of WASH in complementary feeding
- Reflect on key time points for IYCF counselling and their links to key HS contact points.

MATERIALS:

- Flip chart and markers
- Projector
- IYCF Counselling Cards
- Handout: Complementary feeding difficulties and possible counselling discussion points
- Signpost to Somalia Community IYCF Counselling Package 2026, Counsellor's Book Part 1: Key Practices

PREPARATION: Module 5 PowerPoint presentation; IYCF Counselling Cards; handout

DURATION: 90 minutes

RESOURCES:

- UNICEF IYCF Counselling Package
- Somalia Community IYCF Counselling Package 2026, Counsellor's Book Part 1: Key Practices
- Somalia National IMAM Guidelines, FMoH
- IYCF Counselling: An Integrated Course. Course Handouts. WHO and UNICEF, 2021. (Job aids and checklists)

Achieving optimal IYCF behaviours is recognised as one of the most effective interventions to reduce undernutrition, child mortality and disease[21]

Session 9: Timely introduction of appropriate complementary foods at 6 months

This module builds on the IYCF breastfeeding knowledge covered in Module 4 and introduces participants to the knowledge and counselling skills needed to support caregivers on the timely introduction of appropriate complementary feeding at 6 months, while reinforcing continued breastfeeding, WASH practices, and integration of IYCF counselling into routine health service contacts.

[21] Maternal and child nutrition. Lutter, Chesser K et al. The Lancet. 2013; 382(9904):1550-1551.

Session 9 Objective: Participants understand the importance of the timely introduction of appropriate complementary feeding from 6 months, along with continued breastfeeding. They can state recommended complementary feeding practices, describe active and responsive feeding and understand the importance of WASH in complementary feeding.

Theory and discussion *(90 mins)*	a. Introduce the session objectives, emphasising that complementary feeding is in addition to breastmilk rather than replacing it and that continued breastfeeding to 24 months and beyond is recommended. Slides 26 & 27. [Refer to IYCF Counsellor's Book, Part 1: Key Practices Cards 17-21, and Part 2, Unit 10]. b. **Brainstorm** the definition of complementary feeding before presenting Module 5 slides 27-30 [Refer to IYCF Counsellor's Book, Part 1: Key Practices Cards 17-21, and Part 2, Unit 10]. Highlight that: breastmilk continues to provide approximately half of the energy needs of an infant up to 12 months, and one third up to 24 months. Additionally, breastfeeding protects against illness and supports emotional and psychological development. Use the **energy gap** illustration on slide 30 to explain energy requirements from 6-23 months, showing how the gap between total energy needs and energy provided by breastmilk increases with age. Emphasise that complementary foods are needed to fill this gap. c. Facilitate a **short discussion** on the risks of introducing complementary foods to early or late (Slide 31). Ask participants to share any examples from the health facilities or communities. d. Present slides 32-36 on **appropriate complementary feeding** [Refer to IYCF Counsellor's Book, Part 1: Key Practices Cards 17-21, and Part 2, Unit 10]. e. Present slides 37-38 on **active and responsive feeding** and explore together the IYCF Counselling Cards on responsive feeding [Refer to IYCF Counsellor's Book, Part 1: Key Practices Cards 27&28, and Part 2, Unit 7.3] f. Handout 'Complementary feeding difficulties and possible counselling discussion points' (Annex 8) and facilitate a **short discussion** on the common feeding challenges faced by caregivers. g. Present slide 39 on the importance of **WASH** in complementary feeding, highlighting the critical times for handwashing, how food can be safely prepared and stored, the use of clean utensils and clean water, and latrines and how to properly dispose of faeces. [Refer to IYCF Counsellor's Book, Part 1: Key Practices Cards 13-16, and Part 2, Unit 9]. Facilitate a **short discussion** on the importance of WASH in complementary feeding for child health and the prevention of malnutrition. Ask participants to identify and share any high-risk practices they see and how to address these through counselling. h. Summarize the key messages, correct misconceptions if needed, discuss, and fill in any gaps. i. If time allows, introduce the case study below and facilitate the discussion.

Case Study: Timely Introduction of Complementary Feeding

Scenario - Asha is a 23-year-old mother. Her baby, Hodan, is now 6 months old. Hodan was born healthy and was exclusively breastfed for the first six months. Asha attends the health facility with Hodan and tells the health worker that she plans to continue giving only breastmilk because:

- *She believes breastmilk is still enough*
- *She is worried that other foods may cause diarrhoea*
- *Her mother-in-law advised her to wait until Hodan has teeth*

Asha also explains that Hodan:

- *Seems hungry more often*
- *Is breastfeeding very frequently but still cries*

On weighing Hodan it is clear that he has not gained much weight since the last visit.

In small groups ask participants to discuss the following questions:

1. *Is Hodan ready for complementary foods? Why or why not?*
2. *What are the risks if Asha delays introducing complementary foods beyond 6 months?*
3. *What key counselling messages should the health worker give Asha?*
4. *What foods could be recommended as first complementary foods using locally available options?*
5. *At which health service contact points could Asha have received anticipatory counselling before Hodan reached 6 months?*

Key Learning Points:

- *At 6 completed months, breastmilk alone is no longer sufficient to meet energy and nutrient needs.*
- *Delaying complementary feeding increases the risk of:*
  - *Growth faltering*
  - *Underweight and micronutrient deficiencies*
- *Common caregiver concerns (fear of diarrhoea, advice from family members, waiting for teeth) are normal and should be addressed through counselling, not judgement.*
- *Anticipatory counselling before 6 months (e.g. during PNC visits, immunisation or GMP visits) supports timely action.*
- *Complementary foods should:*
  - *Be thick, mashed, and given in small amounts*
  - *Use locally available foods*
  - *Be given while continuing breastfeeding*

Session 10: Integration of IYCF counselling into health service contact points

Session 10 Objective: Participants can identify key time points for IYCF (breastfeeding and complementary feeding) counselling and their links to HS contact points

Brainstorming *(25 mins)*	j. Mention the specific objective of the session: to reflect on how IYCF can be integrated into key health service contact points. k. Ask participants to identify the specific times (contact points) when they as health workers could counsel mothers on recommended breastfeeding and complementary feeding practices at health facilities (or at the community level). Refer to *Figure 15.* l. Write contact points on the left-hand side of a flipchart paper titled "Key contact points for IYCF counselling". m. Review together the **Counselling Cards** and **Counsellor's Book Part 1: Key Practices** that correspond with pregnancy, the post-partum period, exclusive breastfeeding up to six months of age and complementary foods from 12 to 24 months. n. Review together the key time points for breastfeeding counselling shown in *Figure 16* below (Counsellor's Book Part 2: Technical Notes 7.5) ask participants to match these with the key HF contact points previously identified, adding them on the right-hand side of the flip chart. o. Discuss with the participants the best time to counsel caregivers on the timely introduction of appropriate complementary foods at 6 months and complementary feeding (see *Figure 15*). Noting that anticipatory and continuous counselling at health contact points allows for timely action. Add these to the flip chart.

p. Signpost additional complementary feeding (CF) resources on the Global Complementary Feeding Collective website. Note that CF counselling can also take place at the community-level, and HW should connect caregivers with mother-to-mother support groups and other community-based initiatives that support CF.

q. Summarize, correct points if needed, discuss, and fill in any gaps.

<table>
<tr><th colspan="3">Health worker contact points with caregivers</th></tr>
<tr><th colspan="2">At the health facility level</th><th>At the community level</th></tr>
<tr><td colspan="2">ANC visits</td><td>Home visits</td></tr>
<tr><td colspan="2">PNC visits/Skilled Delivery at Birth</td><td>Integrated child health days</td></tr>
<tr><td colspan="2">Child immunisation</td><td>Outreach clinics</td></tr>
<tr><td rowspan="4"></td><td>Penta 6 wks</td><td rowspan="2">EPI outreach days</td></tr>
<tr><td>Penta 10 wks</td></tr>
<tr><td>Penta 14 wks</td><td rowspan="2">National immunisation days</td></tr>
<tr><td>Measles 12 months</td></tr>
<tr><td colspan="2">OPD, Triage/screening points, Maternal and child health department, HIV/AIDS/TB, Kala Azar and support clinics, in-patient clinics or wards</td><td>Religious centres, cattle camps, water collection points, community activities</td></tr>
</table>

Figure 15: Health worker contact points with caregivers at the health facility and community level

FACILITATOR NOTES:

- In Somalia 60% of infants are timely initiated to breastfeeding, and 34% are breastfed exclusively for six months. Only 41% are introduced to complementary foods at six to eight months.
- BF counselling should also consider the mental health of the mother and include discussions with the mother regarding difficulties that she may be experiencing e.g. juggling BF and work responsibilities. Discuss ways to support the mother and refer to psychosocial support as appropriate (signposting to MAMI Counselling Cards).
- The six-week Penta vaccination coincides with the 6-week growth spurt in infants. Explain that the infant may want to feed more often during this growth spurt.
- The 10-week Penta vaccination comes at the point of the second growth spurt at around 3 months. Remind the mother that the infant may want to feed more often at this time.
- Anticipatory and continuous counselling at health contact points allows for timely action, for example the timely introduction of appropriate complementary feeding at 6 months (Figure 17)
- The 12-month measles immunization contact point should be leveraged to ensure that infants are receiving an appropriate diet of complementary foods while breastfeeding continues (*Figure 18*).
- Note that health workers carrying out IYCF counselling should have comprehensive training, be supervised regularly and have dedicated resources and time for this intervention.

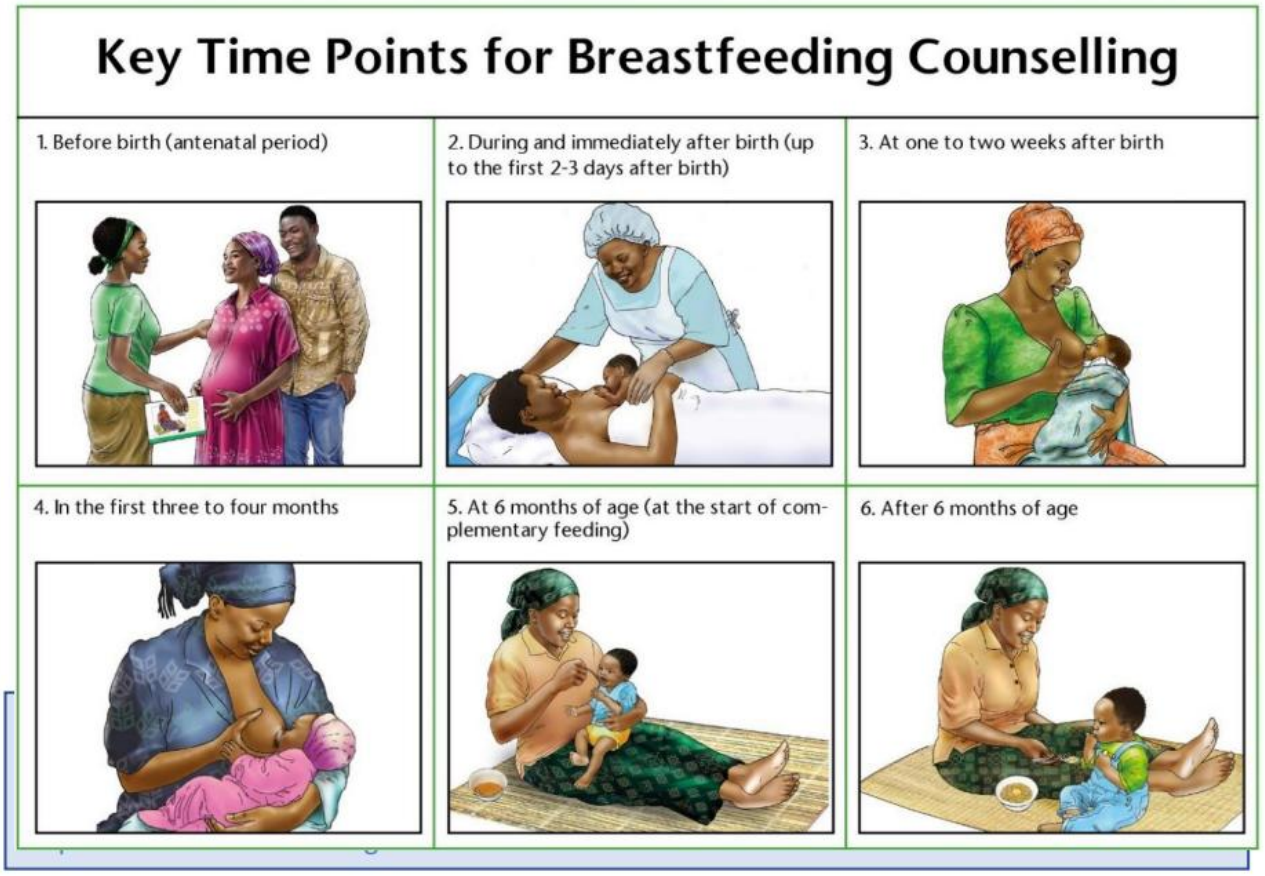


Figure 16: Key time points for breastfeeding counselling

Figure 17: Counselling Card 17 - Start complementary feeding at 6 months

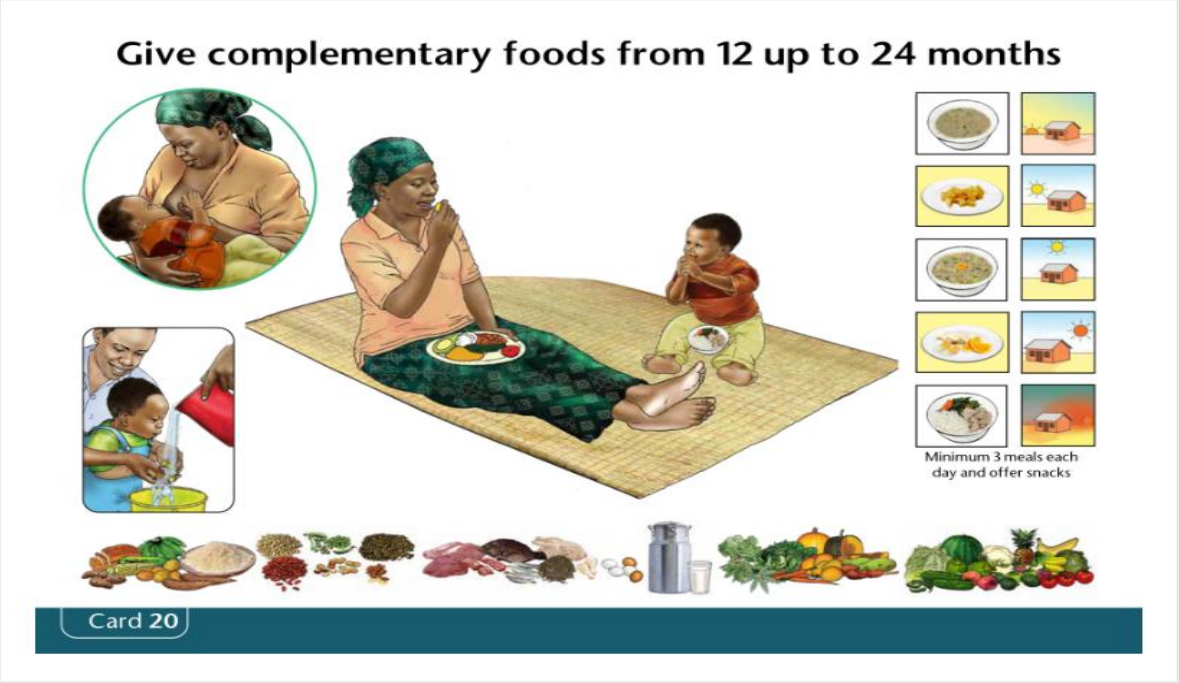


Figure 18: Counselling Card 20 - Give complementary foods from 12 up to 24 months

Module 6 - Growth Monitoring and Promotion

Module 6 Learning Objectives:

- Participants understand the importance of growth monitoring and promotion (GMP) at key contact points, and the role of early identification of infants at risk of poor growth and development (<6 months) in the prevention of wasting.[22]
- Participants can list GMP practices and purposes.

MATERIALS:

- Flip chart and markers
- Projector

  Handout: IMAM Nutrition and Medical Assessment **Slide 46**

PREPARATION: Print copies of the IMAM Nutrition and Medical Assessment and IYCF counselling job aids for each participant.

DURATION: 45 minutes

RESOURCES:

- UNICEF IYCF Counselling Package, Counsellor's Book Part 2: Technical Notes
- Somalia Community IYCF Counselling Package 2026, Counsellor's Book Part 1: Key Practices
- Somalia National IMAM Guidelines, Section 4
- IYCF Counselling: An Integrated Course. Course Handouts. WHO and UNICEF, 2021. (Job aid: weighing and measuring a child, Growth Problems Chart)
- WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years
- WHO Child Growth Standards

Regular growth monitoring identifies children at risk of malnutrition early, enabling timely interventions. The integration of GMP into routine health services strengthens efforts to prevent stunting, wasting, and underweight, supporting overall child health and development

Session 11: Growth Monitoring and Promotion

Session 11 Objectives: Participants understand the importance of both growth monitoring and promotion (GMP) at all contact points, and the early identification of infants at risk of poor growth and development (<6 months) in the prevention of wasting. Participants can list GMP practices and purposes.

Discussion and brainstorming GMP *(45 mins)*	a. Introduce the module and the learning objectives. b. Ask one or two volunteers to outline what GMP means to them. Clarify GMP for participants and highlight the importance of the early identification of infants (<6 months) at risk of poor growth and development. Refer to *Figure 19 below, and*

[22] This module includes information from the new WHO wasting guidelines e.g. refers to infants <6 months who are not growing well. Early identification and appropriate care/referral prevents later wasting.

*IYCF Counsellor's Book Part 2, Unit 12. S*ignpost *Section 4* in the *Revised Somalia IMAM Guidelines.*

c. Ask participants: 'What GMP practices do you currently use, and at which contact points?' Note participant responses on the flip chart. Refer to any GMP practices not currently used and explain their relevance. Refer to *Figure 20.*
d. Ask participants: 'What barriers do you face currently to conducting GMP at HS contact points?' Note participant responses on the flip chart and brainstorm solutions, prioritising peer-to-peer learning and sharing.
e. Share information on the local/district context with regard to wasting and ask participants to share their experience in the health facilities e.g. Ask 'Do you see seasonal variations in the prevalence of wasting at your health facility?'
f. Present slides 41-46, referring to facilitator notes below.
g. Distribute handout '*IMAM Nutrition and Medical Assessment*', explaining its use in the screening of children who are identified as not growing well. (*Slide 45*)
h. Recap the brainstorming and main outcomes of the discussion.
i. Q&A session.

FACILITATOR NOTES:

GMP is a service that should be conducted for every child from 0-59 months each time they visit the health facility (and at each community visit). It refers to the process of tracking child growth by regularly measuring the child and comparing his or her growth (i.e., height and/or weight) to the WHO child growth standards.[23] Measurements should be plotted on growth charts and interpreted to identify growth problems. The assessment of child growth is then linked to tailored nutrition counselling, with referral to other services as necessary. The GMP activity has two main purposes: **Monitoring** - to measure and chart weight of children (and/or height and MUAC); and **Promotion** - to use this information on physical growth to discuss with parents how their child is growing and to counsel them in order to motivate actions that improve growth.

Key Considerations:

A healthy child who is growing well should gain weight every month. If a child is not gaining weight or is losing weight, there is a problem. The child should be assessed for wasting, feeding challenges and medical issues and referred for further attention immediately (see *Figure 22* IMAM Nutrition and Medical Assessment).

A flat (stagnant) child growth line means there is no gain in weight or length/height. For children in age groups where the growth rate is fast, as shown by steep growth curves (e.g. during the first 6 months), even one month stagnation in growth represents a possible problem.

A sharp incline in the growth line may indicate a problem except if the child has been severely undernourished, whereby a rapid gain in the presence of gaining height might indicate "catch up growth".

[23] https://www.who.int/tools/child-growth-standards

- Malnourished children, particularly those with severe wasting and/or nutritional oedema, have up to 11 times higher risk of death from common childhood illnesses.
- In Somalia, 12% of children under five are wasted and 23% are underweight.
- Early identification of infants at risk of poor growth and development lowers the risk of wasting developing and could result in improved health outcomes.
- We need to always consider the needs of the mother and manage the mother and infant together.
- Benefits for the mother and infant: The child will be less likely to growth falter, and the mother less likely to introduce other liquids or foods than breastmilk. The mother may also be less likely to experience stress and worry about her infant.

Infants <6 months who are at risk of poor growth and development are identified through any of the following 4 categories:

- **Poor birth outcomes**: LBW, SGA, pre-term
- **Poor anthropometry** based on a single measure: MUAC <11.0 from 6 weeks to 6 months or weight-for-age z-score (WAZ) <-2 or WLZ <-2 or nutritional oedema
- **Poor growth** based on sequential measures – stagnant indicators or weight loss/MUAC reduction
- **Known risk factors** including feeding concerns, maternal risk (physical or mental health problems affecting caring practices) or a history of hospitalisation.

Figure 19: Wasting/Nutrition vulnerability in infants under 6 months of age

- Benefits for health workers: Fewer infants develop wasting, alleviating workload. Less workload for CMAM programme. Less dissatisfaction with care. Greater job satisfaction.

Growth Monitoring and Promotion Practices	
Weigh child	Assess mother's mental wellbeing
Measure child's length / height	Give IYCF counselling
Look at child's growth chart	Give BF counselling
Interpret infant's weight for age	Take MUAC measurement (6-59 months)
Update infant / child's growth chart	Deworming (>12 months)
Vitamin A supplementation (6-59 months)	Other activities

Figure 20: Growth Monitoring and Promotion Practices

Passive screening should be carried out in all health structures. Any child (6 to 59 months old) with a MUAC of less than 125mm but more than or equal to 115mm should be referred for treatment of moderate malnutrition. In health facilities, take the weight and height/length of all those with a MUAC below 125mm. Older children (more than 5 years of age) and adolescents can be severely malnourished without fulfilling the MUAC criteria for SAM; they should have their weight and height taken if they are suspected of being malnourished and treated according to the latest IMAM protocol.

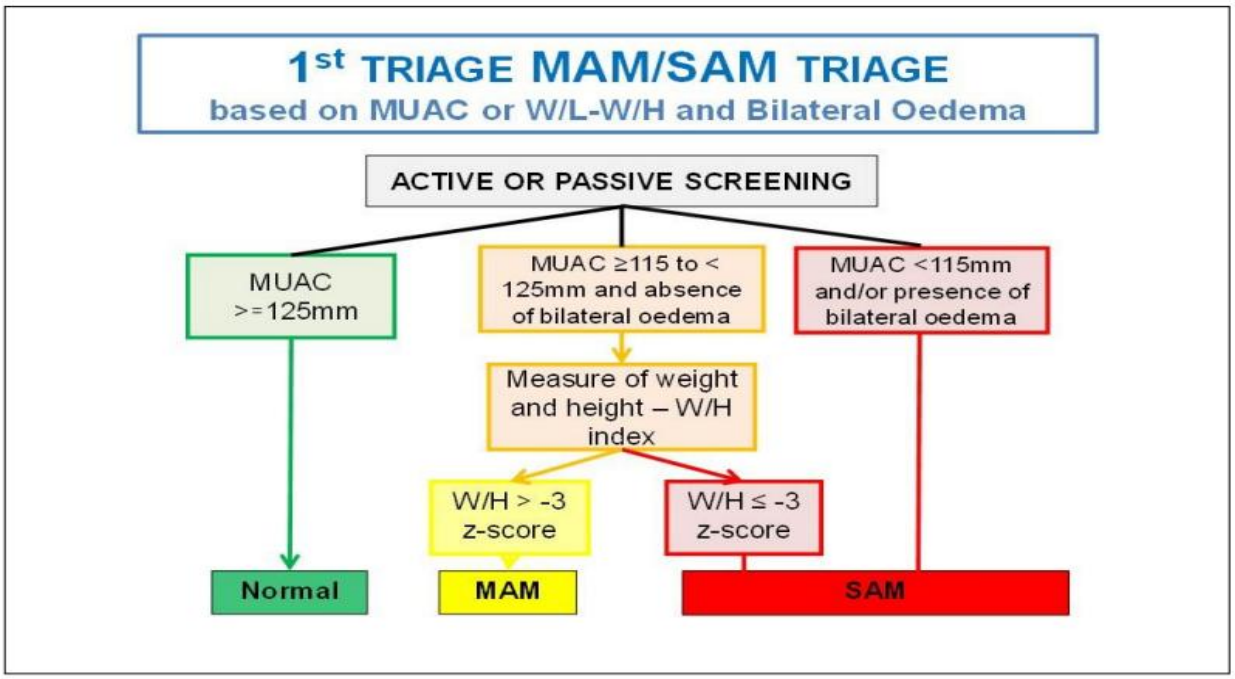


Figure 21: Nutritional Strategy for Screening and Triage for Acute Malnutrition

Source: IMAM Guidelines, MOH Somalia, 2023

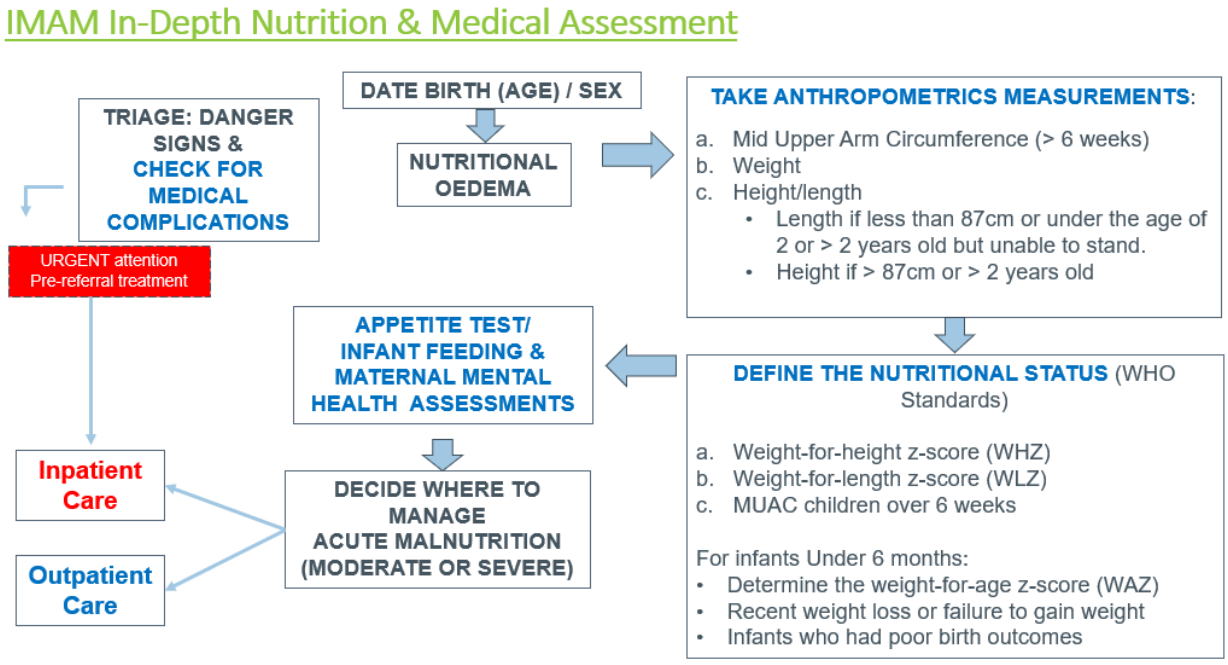


Figure 22: IMAM In-Depth Nutrition and Medical Assessment

Final Session - Post-training Assessment

Final Session: Post-Training Assessment and close out - 35 minutes

Session Objective: Measuring knowledge gained through the training, highlight specific areas where participants have improved and areas where further clarification may be needed.	
Written post-training assessment *(25 mins)*	1. Distribute copies of the post-training assessment (*Annex 1*) to the participants and ask them to complete the test individually. 2. Ask participants to write their code number (previously assigned) on the test (participants should use the same number as for the pre-training assessment). 3. Mark completed assessments during the session and leave time for any questions. Participants who obtain a final assessment score of 80% or above will receive a certificate of completion.
Feedback forms	Ask participants to complete the feedback forms anonymously and return at the end of the session.

Annex 1: Participant Copy – Pre- and Post-Training Assessment: What do we know now?

Participant code: Date:

Qu.	Statement	Yes	No	Don't Know
1	Nutrition counselling of pregnant and lactating women should take place at each visit with a heath worker.			
2	I feel confident in my ability to advise a pregnant woman about nutrition during ANC visits.			
3	The amount and types of food a woman eats during pregnancy can affect a baby's health.			
4	Poor child feeding during the first 2 years of life harms growth and brain development.			
5	An infant aged 6 to 9 months needs to eat at least 3 times a day in addition to breastfeeding.			
6	A pregnant woman needs to eat additional, nutritious food each day.			
7	Telling a mother how to feed her child is the most effective way of changing her infant feeding practices.			
8	The more milk a baby removes from the breast, the more breast milk the mother makes.			
9	Suboptimal breastfeeding practices are linked to infant mortality.			
10	During the first 6 months, a baby living in a hot climate needs water in addition to breast milk.			
11	A young child (aged 6 to 24 months) should not be given animal foods such as eggs and meat.			
12	A newborn baby should always be given colostrum (the first thick, yellowish breast milk).			
13	Pregnant and/or lactating adolescents require the same amount of food as a fully developed PL woman.			
14	Nutrition interventions should be included at each health service contact point with women, adolescents, infants and children.			
15	Severe iron deficiency may lead to anaemia, spontaneous abortion or low-birth-weight.			
16	It is only important to monitor the weight of the child, not of the mother.			
17	Pregnant and lactating women are at greater risk of undernutrition than other groups in the population.			
18	One of the major causes of low-birth-weight is maternal malnutrition.			
19	Growth monitoring and promotion at health service contact points plays an important role in the reduction of wasting.			
20	Assessing the growth of the child is sufficient to improve child health.			

Annex 2: Session 3 - Pile Sort Activity – An introduction to nutrition in the first 1000 days. Pile Sort Cards.

Print and cut sufficient cards for groups to have one complete set of cards each. It is preferable to laminate the cards for multiple uses.

1 Good maternal nutrition, health and physical status help to prevent low birth weight and subsequent stunting.	2 Pregnancy increases nutrient needs
3 Pregnancy to 2 years old (the first 1000 days) is the most crucial time to meet a child's nutritional needs and address stunting.	4 A low birth weight baby / wasted / underweight infant is **not** more susceptible to communicable diseases than a normal weight infant.
5 Poor growth can be aggravated by frequent incidence of infection diseases.	6 All of the following practices can lead to poor growth after birth: inadequate breastfeeding practices, poor access to diverse types of food, inadequate intake of micronutrients.
7 Pregnancy in adolescence is not more likely to result in a low-birth weight baby.	8 A stunted child will have a normal cognitive capacity.
9 Breastfeeding is the most cost-effective intervention to reduce child mortality.	10 Micronutrient needs for iron, vitamin A and folic acid can always be met through the local diet.

11 The short-term consequences of undernutrition are increased morbidity, mortality and disability.	12 The long-term consequences of undernutrition include: reduced adult height, cognitive ability, economic productivity and increased risk of metabolic and cardiac disease.
13 The immediate causes of maternal and child undernutrition are: inadequate dietary intake, disease and inadequate health services.	14 Growth faltering usually begins at about 6 months of age, with a rapid decline through 12 months.
15 The effects of malnutrition (including child stunting and wasting) on mental and physical development contribute to poor productivity, low economic growth, and the continuation of poverty.	16 Any damage to physical growth and brain development that occurs during this period is likely to be extensive and, if not corrected, may be irreversible.

Annex 3: Protocol for Micronutrient Support

Protocol for Micronutrient Support[24]

VITAMIN A

Key message for mothers/caregivers: Vitamin A protects immunity, reduces the risk of children dying from common childhood diseases and prevents blindness.

Higher doses of Vitamin A supplementation than recommended can result in toxicity

PREVENTION		
A.TO PREVENT VITAMIN A DEFICIENCY **HIGH DOSE OF VITAMIN A SUPPLEMENTATION DURING PREGNANCY SHOULD BE AVOIDED BECAUSE IT CAN CAUSE MISCARRAIGE AND BIRTH DEFECTS.**		
Age Group	**Dose**	**Duration**
Infants 6 to 11 months	**100,000 IU** **3 drops from red capsule or 1 blue capsule**	**single dose every 4-6 months**
Children 12 to 59 months	**200,000 IU** **1 red capsule or 2 blue capsules**	**single dose every 4-6 months**
TREATMENT		
B. FOR TREATMENT OF CHILDREN WITH PROLONGED OR SEVERE DIARRHOEA, ARI, CHICKEN POX, SEVERE MALNUTRITION AND OTHER SEVERE INFECTIONS. **DO NOT GIVE IF: IF OEDEMA IS PRESENT OR IF CHILD RECEIVED VITAMIN A WITHIN LAST 4-6 MONTHS.**		
Infants < 6 months of age (if not breastfed)	**50,000 IU** **1 white capsule**	**single dose**
Infants 6 to 11 months	**100,000 IU** **3 drops from red capsule or 1 blue capsule**	**single dose**
Children 12 months or older	**200,000 IU** **1 red capsule or 2 blue capsules**	**single dose**
C. FOR TREATMENT OF MEASLES.		
Infants < 6 months	**50,000 IU** **1 white capsule**	**1 dose immediately (Day 1)** **1 dose next day (Day 2)** **1 dose after 2 weeks, if eye signs are present (Day 15)**
Infants 6 to 11 months	**100,000 IU** **3 drops from red capsule or 1 blue capsule**	**1 dose immediately (Day 1)** **1 dose next day (Day 2)** **1 dose after 2 weeks, if eye signs are present (Day 15)**

[24] Maternal, Infant and Young Child and Adolescent Nutrition Operational and Programmatic Guidelines, Somalia, 2023

Children 12 months and older	200,000 IU 1 red capsule or 2 blue capsules	1 dose immediately (Day 1) 1 dose next day (Day 2) 1 dose after 2 weeks, if eye signs are present (Day 15)

Habraaca

TAAGEERIDA NAFAQOOYINKA YAR YAR

FITAMIN A

Fariin muhiim u ah hooyooyinka/xanaaneeyaha: Fitamin A wuxuu dhisaa difaaca jirka, wuxuu yareeyaa halista dhimasho ee caruurta qaba xanuunada ay caruurta u dhintaan iyo kahortagida indha la'aanta.

In laqaato qiyaas Fitamin A inkabadan intii lagutaliyey waxay keeni kartaa sumowbid

KAHORTAGA		
A.KAHORTAGA IN AY QOFKA KUYARAATO FITAMIN A-GA QIYAASTA BADAN EE FITAMIN A-GA XILIYADA UURKA WAA IN LAGAFOGAADAA SABABTOO AH WAXAY KEENI KARTAA ILMAHA OO SOODHACA AMA NUQSAAN KUDHASHAAN		
DA'DA	QIYAASTA	MUDADA
Dhalaanka jira 6 ilaa 11 bilood	100,000 IU 3 dhibcood kaabsool-ka cas ama 1 xabo kaapsool-ka buluuga ah	hal qiyaas 4-6 dii bil kasta
caruurta jirta 12 ilaa 59 bilood	200,000 IU 1 kaapsool-ka cas ama 2 kaapsool oo buluug ah.	hal qiyaas 4-6 dii bil kasta
DAAWEYNTA		
B. DAAWEYNTA CARUURTA EE QABA SHUBANKA DABADHEERAADAY AMA DARAN, XANUUNKA NEEFMAREENKA, FURUQA, NAFAQO XUMI AAD U DARAN IYO CAABUQYO DARAN. HASIININ: HADDII UU BARAR JIRO AMA CANUGA HADDII UU SOOQAATAY FITAMIN A 4-6 DII BILOOD EE UGU DAMBEYSAY.		
Dhalaanka jira kayar < 6 bilood (waa haddii aan naaska lanuujin)	50,000 IU 1 kaabsool-ka cadaanka ah	hal qiyaas
Dhalaanka jira 6 ilaa 11 bilood	100,000 IU 3 dhibcood kaabsool-ka cas ama 1 xabo kaabsool-ka buluuga ah	hal qiyaas
caruurta jirta 12 ilaa 59 bilood	200,000 IU 1 kaabsool-ka cas ama 2 kaapsool oo buluug ah.	hal qiyaas
C. KUDAAWEYNTA JADEECADA		

Dhalaanka jira **< 6 bilood**	**50,000 IU** **1 kaabsool-ka cadaanka ah**	**1 qiyaas marka hore (maalinta 1aad)** **1 qiyaas maalinka xiga (maalinta 2 aad)** **1 qiyaas 2 isbuuc kadib, waa haddii calaamadaha xanuunka indhaha uu jiro (maalinta 15 aad)**
Dhalaanka jira **6 ilaa 11 bilood**	**100,000 IU** **3 dhibcood kaabsool-ka cas ma 1 xabo kaapsool-ka buluuga ah**	**1 qiyaas marka hore (maalinta 1aad)** **1 qiyaas maalinka xiga (maalinta 2 aad)** **1 qiyaas 2 isbuuc kadib, waa haddii calaamadaha xanuunka indhaha uu jiro (maalinta 15 aad)**
caruurta jirta **12 ilaa 59 bilood**	**200,000 IU** **1 kaabsool-ka cas ama 2 kaapsool-ka buluuga ah.**	**1 qiyaas marka hore (maalinta 1aad)** **1 qiyaas maalinka xiga (maalinta 2 aad)** **1 qiyaas 2 isbuuc kadib, waa haddii calaamadaha xanuunka indhaha uu jiro (maalinta 15 aad)**

MULTIPLE MICRONUTRIENT TABLETS

Key message for women: These tablets contain a number of vitamins and minerals that will make you and your baby strong and healthy.

PREVENT		
A. TO PREVENT MICRONUTRIENT DEFICIENCIES		
Age Group	**Dose**	**Duration**
Pregnant Women	**1 tablet daily** **.**	**For duration of pregnancy**
Lactating Women	**1 tablet daily**	**Until infant is 6 months old**
Adolescents and other women of child-bearing age	**1 tablet daily**	**No limit**
Advise women to take the multiple micronutrient tablet with a meal to avoid any side-effects of nausea		

KANIINIYAASHA NAFAQADA YAR YAR KAKOOBAN

Fariimo muhiim u ah haweenka: kaniiniyadaan waxay kakooban yihiin tiro Fitamiino iyo macaadiin ah kaasoo kadhigeysa adiga iyo canugaaga mid xoog leh cafimaadna qaba.

KAHORTAG		
A. KAHORTAGIDA NAFAQOOYINKA YAR YAR IN UU YARAADO		
DA'DA	**QIYAASTA**	**MUDADA**
Haweenka Uurka leh	**1 kaniini maalintii** **.**	**inta lagu guda jiro uurka**

Haweenka nuujinaya	**1 kaniini maalintii**	**ilaa dhalaankeeda uu ka gaarayo 6 bilood**
dhalinyarada iyo haweenka kujira da'da dhalida	**1 kaniini maalintii**	**xad malahan**
kulatali haweenka in kaniiniyaasha nafaqada yar yar kakooban ay kulaqaataan cunto si ay ogafogaadaan waxyeeladiisa sida lalabada.		

ZINC

Key messages: Emphasize the need to ensure handwashing with soap or ash after visiting the toilet and before preparing or eating food.

TREATMENT		
A. TO TREAT DIARRHEA **Zinc supplementation and ORS are not advised for children with severe acute malnutrition**		
Age Group	**Dose**	**Duration**
Infants < 6 months	**½ tablet (10mg) per day**	**10 to 14 days**
Children > 6 months and beyond	**1 tablet (20mg) per day**	**10 to 14 days**
Advise the mother on how to prepare and give the zinc. Also provide at least 2 sachets of ORS to take during diarrheal illness. **Refer to IMAM guidelines for how to manage cases of diarrhea in children who are severely malnourished**		

Habraaca

TAAGEERIDA NAFAQOOYINKA YAR YAR

ZINC

Fariimo muhiim ah: Dhiira gali baahida looqabo in laxaqiijiyo gacmaha in lagudhaqo saabuun ama dambas kadib isticmaalka musqusha iyo kahor diyaarinta ama cunida cuntada.

DAAWEYNTA		
A. DAAWEYNTA SHUBANKA **Zinc iyo ORS lagumatalinayo in lasiiyo caruurta qaba nafaqo yarida aadka u daran.**		
DA'DA	**QIYAASTA**	**MUDADA**
Dhalaanka <6 bilood	**½ haaf kaniini (10mg) maalintii**	**10 ilaa 14 maalmood**
Caruurta > 6 bilood iyo kasiisareeya	**1 kaniini (20mg) maalintii**	**10 ilaa 14 maalmood**
talo kasiiyo hooyada sida loodiyaariyo loonabixiyo Zinc. Sidoo kale sii uguyaraan 2 xidhmo oo ORS ah oo laqaadanayo xiliga xanuunka shubanka uu jiro. **Refer to IMAM guidelines for how to manage cases of diarrhea in children who are severely malnourished** **ka eeg "Habraac Hagida IMAM" sida loolatacaalo shubanka ee qaba caruurta nafaqo yaridoodu daran tahay.**		

DEWORMING

Key messages: To avoid re-infection, emphasize the need to ensure handwashing with soap or ash after visiting the toilet and before preparing or eating food.

PREVENTION & TREATMENT		
A. TO PREVENT or TREAT INFESTATIONS		
Age Group	**Dose**	**Duration**
Infants < 12 months	**Do not give any deworming drugs!**	**N/A**
Children 12-23 months	½ **tablet** of Albendazole (400 mg)	**single dose**
Children 24 months & older	**1 tablet** of Albendazole (400 mg)	**single dose**
Pregnant Women (from the 2nd trimester ONLY)	**1 tablet** of Albendazole (400 mg)	**single dose**

GOORYAAN DILID

Fariimo Muhiim ah: si loogahortago in uu jeermiska soolaabto, dhiira gali baahida looqabo in laxaqiijiyo gacmaha in lagudhaqo saabuun ama dambas kadib isticmaalka musqusha iyo kahor diyaarinta ama cunida cuntada.

KAHORTAG & DAAWEYN		
A. KAHORTAGA IYO DAAWEYNTA JEERMISKA		
DA'DA	**QIYAASTA**	**MUDADA**
Dhalaanka <12 bilood	**Hasiin daawooyinka gooryaanka**	**Malahan**
Caruurta 12-23 bilood	½ **half kaniini** oo Albendazole (400 mg) ah	**Hal qiyaas**
Caruurta 24 bilood & kasiiweyn	**1 kaniini** oo Albendazole (400 mg) ah	**Hal qiyaas**
Haweenka Uurka leh (lagabilaabo teeramka 2 aad oo KALIYA)	**1 kaniini** oo Albendazole (400 mg) ah	**Hal qiyaas**

Annex 4: Module 3 - Participant Handouts

Module 3: Session 6 – BMI Calculation Worksheet

Activity: BMI Calculation Practice

Objective:

To practice calculating BMI accurately using height and weight data.

Why BMI is important:

In pregnant women, assessing BMI at the beginning of pregnancy (≤20 week's gestation) is important for several reasons:

- **Identifying Nutritional Risks**: Low or high BMI can indicate risks for both the mother and baby. Underweight women may be at risk for delivering low birthweight babies, while overweight and

obese women are at greater risk of pregnancy complications like gestational diabetes, hypertension, and birth complications.

- **Guiding Nutritional Interventions**: Knowing a pregnant woman's BMI helps to provide tailored dietary and lifestyle recommendations to support healthy weight gain during pregnancy. This is crucial for foetal growth and reducing the risk of pregnancy complications.

By monitoring BMI in pregnant women, early action can be taken to address potential nutritional risks, contributing to healthier outcomes for both the mother and baby.

BMI formula:

$$\text{BMI} = \frac{\text{Weight (kg)}}{\text{Height (m)}^2}$$

Note: BMI = weight (lb) ÷ height^2 (inches) * 703 (to convert feet to inches, multiply feet x 12 e.g. 5ft 2 inches = (5 x 12) + 2 or 62 inches).

- Calculate the BMI for the following women[25]:
  - Woman A: Height 1.65m, weight 60kg
  - Woman B: Height 1.75m, weight 80kg
  - Woman C Height 1.60m, weight 45kg

- Classify the weight of each woman according to the BMI categories below (i.e. underweight, normal weight, overweight or obese).

Nutritional status	Pre-pregnancy BMI or BMI ≤ 21 weeks gestation	Recommended weight gain
Underweight	< 18.5 kg/m2	12.5–18 kg
Normal weight	18.5–24.9 kg/m2	11.5–16 kg
Overweight	25–29.9 kg/m2	7–11.5 kg
Obese	> 30 kg/m2	5–9 kg

Trimester	Weight gain per month
1st trimester	0.5 kgs per month
2nd trimester	1 – 1.5 kgs per month
3rd trimester	2 kgs per month

All pregnant and lactating women should also be systematically screened for acute malnutrition and those whose MUAC is < 21cm should be given further nutritional support.

Admission criteria	Under nutrition status
PLW with MUAC ≥ 18 - ≤ 21cm	Moderate Acute Malnutrition

[25] An online BMI calculation tool could be used for this activity

PLW discharged from stabilization centers with MUAC ≥ 18 - ≤ 21cm	
PLW who are < 18cm MUAC	Severe Acute Malnutrition (OTP/SC management)

Module 3: Session 6 – Maternal Nutrition Interventions at Health Service Contact Points (Participant's Grid)

Health Facility Contact Point	Maternal Nutrition Intervention
1st ANC visit (8-12 weeks of pregnancy)[1]	
2nd ANC visit (24-26 weeks of pregnancy)	
3rd ANC visit (32 weeks of pregnancy)	
4th ANC visit (36-38 weeks of pregnancy)	

Skilled Delivery at Birth	
Childhood Immunisation: Penta vaccine 1st dose (6 weeks)	
Childhood Immunisation: Penta vaccine 2nd dose (10 weeks)	
Childhood Immunisation: Penta vaccine 3rd dose (14 weeks)	
Childhood Immunisation: Measles vaccine (12 months)	

[1] As per WHO FANC model for recommended timing and frequency of ANC visits.

Module 3: Session 6 – Maternal Nutrition Interventions at Health Service Contact Points – Intervention Cards

• MMS • Iron and folic acid supplementation • MUAC screening • Routine monitoring of weight – calculate BMI for baseline • Counselling on healthy eating and physical activity during pregnancy	• BF counselling and support (exclusive breastfeeding to 6 months) • Iron and folic acid supplementation for the mother (3 months postpartum) • MUAC (mother) <21cm = referral • Verify MMS supplies and adherence for mother
• Deworming • Verify MMS supplies and adherence • Verify iron and folic acid supplementation supplies and adherence • MUAC screening • Routine monitoring of weight gain • Counselling on healthy eating and physical activity during pregnancy	• BF counselling and support (exclusive breastfeeding to 6 months). Advise mother/caregivers of the second growth spurt at around 3 months. Remind the mother that the infant may want to feed more often at this time. • Iron and folic acid supplementation for the mother (3 months postpartum) • Verify MMS supplies and adherence for mother • MUAC (mother) <21cm = referral
• Verify MMS supplies and adherence • Verify iron and folic acid supplementation supplies and adherence • MUAC screening • Routine monitoring of weight gain • Counselling on healthy eating and physical activity during pregnancy	• BF counselling and support (exclusive breastfeeding to 6 months). *Note:* coincides with the 3-month growth spurt in infants. Explain that the infant may want to feed more often during this growth spurt. • MUAC (mother) <21cm = referral • Verify MMS supplies and adherence for mother to 6 months postpartum
• Verify MMS supplies and adherence • Verify iron and folic acid supplementation supplies and adherence • MUAC screening • Routine monitoring of weight gain • Counselling on healthy eating and physical activity during pregnancy • BF counselling in preparation for birth	• BF: remind the mother/caregiver that one third of the child's energy needs between 12 and 24 months should come from breastmilk. • MUAC (mother) <21cm = referral • Family Planning
• Early initiation of breastfeeding, skin-to-skin contact, exclusive breastfeeding, rooming-in, responsive on-demand feeding • BF counselling and support	

Module 3 Handout: Key content for the nutritional counselling of women and adolescent girls during preconception, pregnancy and postnatal care

Content	Preconception	Pregnancy	Postnatal
Dietary intake			
Healthy eating and physical activity to stay healthy, attain or maintain a healthy weight and/or prevent excessive weight gain	●	●	●
Increase daily energy and protein intake to increase body mass index and/or reduce the risk of low birthweight infants in undernourished populations	●	●	●
Diverse diet, including locally available and affordable nutritious foods and fortified foods (iodized salt and fortified foods)	●	●	●
Avoid drinking tea or coffee with meals and limit the amount of coffee during pregnancy in contexts where tea or coffee are commonly consumed	●	●	●
Adequate rest and reducing heavy workloads		●	●
Dietary supplementation			
Continued and consistent use of iron-containing supplements, including how to take supplements and manage side-effects	●	●	●
Continued and consistent use of calcium supplements in countries with low calcium intake, including how to take supplements and manage side-effects		●	
Continued and consistent use of balanced energy-protein supplements in undernourished populations	●	●	●
Breastfeeding			
Breastfeeding (initiation immediately after delivery, providing colostrum, not giving prelacteal feeds, exclusive breastfeeding, continued breastfeeding, managing breastfeeding problems)		●	●
Hygiene			
Handwashing practices at critical times and food hygiene practices (safe handling, preparation and storage of food)	●	●	●

Source: Counselling to Improve Maternal Nutrition, A Technical Brief, UNICEF 2022

Annex 5: Module 4 - Participant Handouts

Module 4: Session 7 handout: The benefits of breastfeeding to the mother, child, family and community.

Benefits to the Infant/ Child	Benefits to the Mother	Benefits to the Family	Benefits to the Community/ Society
• Breast milk contains antibodies that protects the infant/child from infectious diseases such as diarrhoea and respiratory infections • All the required nutrients are readily available at the right quantity and temperature	• Promotes a quick recovery after delivery as it prevents heavy bleeding • Reduces risk of breast and ovarian cancers, heart disease and diabetes • Stimulates production of more breastmilk	• Economical as no expenses involved in buying infant formula, firewood or other fuel, or utensils for the baby • Mothers and children are healthier, so medical costs are reduced • Promotes child spacing in families	• Economical as money is saved and used for other needs • Increased productivity in the society due to healthy and productive population • Savings in the health sector due to less illnesses in children

• Breastmilk is easily digested hence nutrients are well absorbed • Protects against allergies. Breast milk antibodies protect the baby's gut preventing harmful substances to pass into the blood • Provides adequate water needs for the baby (87% of water and minerals) • Helps jaw and teeth development; suckling develops facial muscles	• Improves birth spacing if done exclusively for 6 months and amenorrhoea persists • Promotes bonding between mother and child • Reduces maternal workload (time taken to prepare feeds) as it is always available and in the correct temperature		• Improved child survival • Does not generate waste/ pollute the environment

Module 4: Handout – Job Aid: Postnatal Contacts

JOB AID: POSTNATAL CONTACTS

- Use counselling skills – LISTENING AND LEARNING SKILLS and SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT
- Follow up on previous observations and questions

Ask:

- How is breastfeeding going – how many times, length of feeds, comfort, condition of breasts
- Is the baby receiving other fluids or foods, bottles, dummies?
- Baby's health and behaviour
- Pregnancy, delivery, early feeds
- Mother's condition and family planning
- Previous infant feeding experience
- Family and social situation – support at home, work

Observe:

- Condition of the mother
- Condition of the baby
- A breastfeed – including condition of the breasts
- Child's growth curve – weight and/or length/height, as appropriate

Help the mother to:

- Position and attach her baby if necessary
- Express milk and cup-feed her baby – if necessary, if not done before

Explain or recap as needed:

- How milk "comes in"
- Feeding pattern – demand feeding (baby with mother, respond day and night, let baby finish first breast, offer second)
- Exclusive breastfeeding – supplements not needed
- Signs the baby has what they need – passing urine, contented

Respond to any other questions and worries:

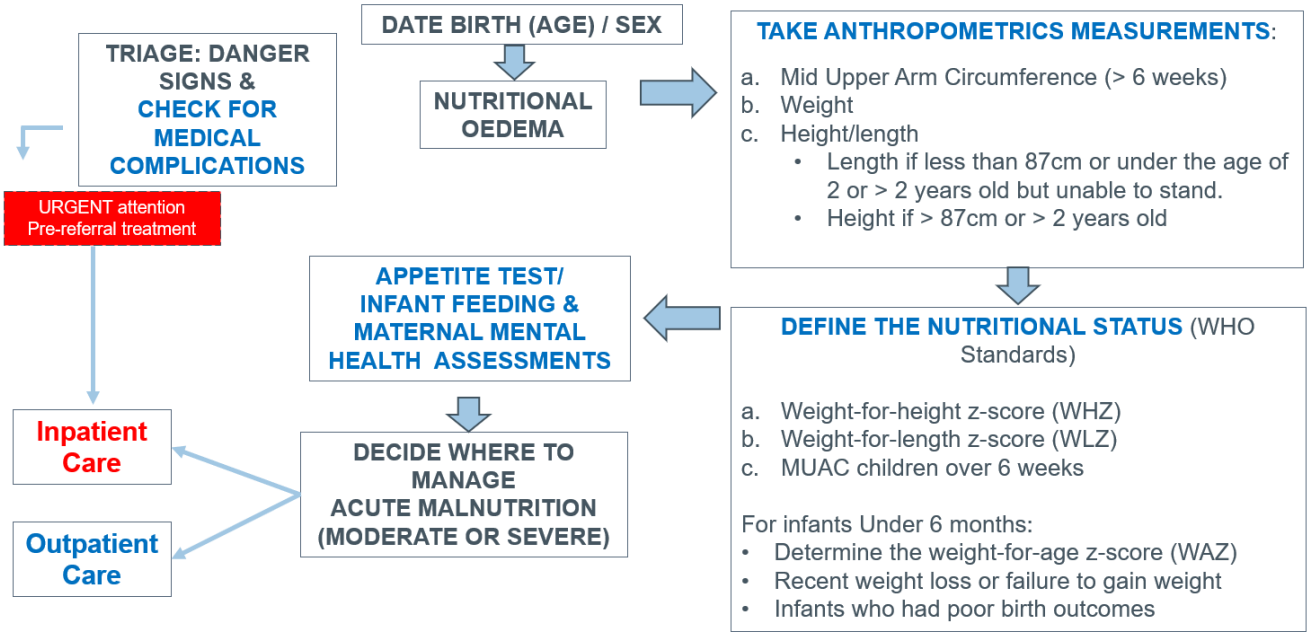
- Help (including possible referral) if needed with any difficulties:
  - Poor (or excessive) weight gain
  - Concerns about "not enough milk"
  - Concerns about baby's crying
  - Suckling difficulties
  - Flat, inverted or large nipples
  - Sore nipples
  - Engorgement
  - Mastitis
  - Refusal to feed

Source: IYCF Counselling, An Integrated Course. Course Handouts, WHO and UNICEF, 2021

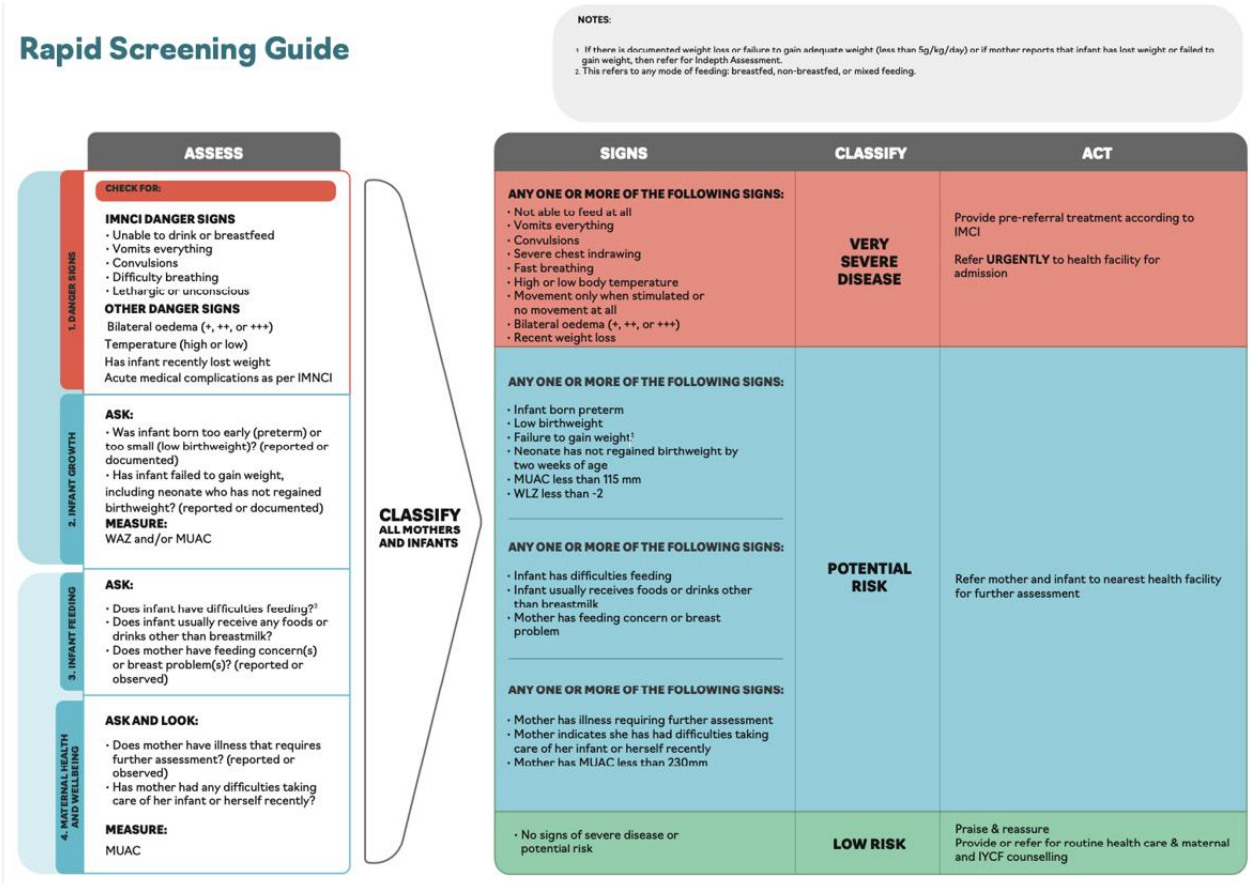
Annex 6: Module 6 - Participant Handouts

Module 6: Session 10 handout – IMAM Nutrition and Medical Assessment

IMAM In-Depth Nutrition & Medical Assessment



Annex 7: Rapid Screening Guide: Mother-infant pair (infants <6 months)



Source: Somalia National Guideline on the Prevention and Management of Wasting and/or Nutritional Oedema (Acute Malnutrition), 2025

Annex 8: Module 5, Session 9 Handout

Complementary feeding difficulties and possible counselling discussion points

Recommended complementary feeding practices	Possible counselling discussion points
After the baby reaches six months of age, add complementary foods such as thick porridge 2 to 3 times a day in addition to breastfeeding	• Give local examples of first types of complementary foods such as staples, roots and tubers. • If possible, use milk instead of water to cook the porridge. • Breast milk can be used to moisten the porridge.
As the baby grows older, increase feeding frequency, amount, texture and variety	• Gradually increase the frequency, the amount, the texture and the variety of foods, especially animal source foods.
From ages 6 - 9 months, continue breastfeeding and add 2 to 3 meals, and	• Start with 2 to 3 tablespoonfuls of cooked porridge or mashed foods such as cereals and food cooked for the family. • At 6 months these foods are more like 'tastes' than actual servings.

offer 1 to 2 snacks per day	• Make the porridge with milk, especially breast milk. Pounded groundnut paste or a small amount of oil may also be added. • Increase the 'tastes' to servings gradually, up to half (½) cup. (250 ml cup). Show the amount using a cup brought by the mother. • Any food can be given to children older than 6 months, as long as it is mashed or chopped. Children do not need teeth to consume foods such as eggs, meat, and green leafy vegetables.
Complementary feeding from ages 9 -12 months. Breastfeed plus give 3 to 4 meals, and offer 1 to 2 snacks per day.	• Give finely chopped, mashed foods, and finger foods. • Increase gradually to ½ cup. (250 ml cup). Show amount in the cup brought by the mother. • Animal source foods are very important and can be given to young children. Cook well and cut into very small pieces.
Complementary feeding from 12 to 24 months. Give 3 to 4 meals and offer 1 to 2 snacks per day, with continued breastfeeding.	• Give food from different food groups. • Give three-quarter (¾) to one cup (250 ml cup/bowl). Show amount in cup brought by mother. • Foods given to the child must be prepared and stored in hygienic conditions to avoid diarrhoea and illness. • Food stored at room temperature should be used within 2 hours of preparation.
Give baby 2 to 3 foods from different food foods: staples, legumes, vegetables/fruits and animal foods at each serving	Try to give food from different food groups at each serving. For example: • Animal source foods: flesh foods such as chicken, fish, liver, and eggs and milk and milk products (1 star* foods) • Staples: grains such as maize, wheat, rice millet and sorghum and roots and tubers such as sweet potatoes, potatoes (2 star** foods) • Legumes such as beans, lentils, peas, groundnuts and seeds such as sesame (3 star*** foods) • Vitamin A-rich fruits and vegetables such as mango, papaya, passion fruit, dark-green leaves, carrots, yellow-fleshed sweet potatoes and pumpkin, and other fruits and vegetables such as banana, pineapple, watermelon, tomatoes, avocado, eggplant and cabbage (4 star**** foods). • Add a small amount of fat or oil to give extra energy. Additional oil will not be required if fried foods are given, or if the baby seems healthy or fat.
Continue breastfeeding for children aged two years and older.	• During the first and second years, breast milk is an important source of nutrients for the baby. • Breastfeed between meals and after meals. Do not reduce the number of times the child is breastfed.
Be patient and actively encourage the baby to eat all of their food	• At first the baby may need time to get used to eating foods other than breast milk. • Use a separate plate to feed the child to make sure they eat all the food given.
Wash hands with soap and water before preparing food, eating, and feeding young children. Wash the baby's hands before eating.	• Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhoea and other illnesses. • Wash your hands with soap and water after using the toilet and washing or cleaning the baby's bottom.
Feed the baby using a clean cup and spoon.	• Cups are easy to keep clean • Use a drying rack
Encourage the child to breastfeed more and continue eating during illness, and provide extra food after illness.	• Fluid and food requirements are higher during illness. • Children who have been sick need extra food and should be breastfed more frequently to regain the strength and weight lost during the illness. • Take advantage of the period after illness when their appetite is back to make sure the child makes up for their loss of appetite when they were sick.

Annex 10: References

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